

Painkiller (Ab)use:

**The discursive construction and lived
experience of non-medical consumption**

George Christopher Dertadian

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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(Signature)

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List of Abbreviations

ABS	Australian Bureau of Statistics
ADHD	Attention deficit hyperactivity disorder
AIC	Australian Institute of Criminology
AOD	Alcohol and other drugs
APA	American Psychiatric Association
APC	Aspirin, phenacetin and caffeine products
ASMI	Australian Self Medication Industry
DEA	Drug Enforcement Agency (American)
DORA	Drugs and Poisons Information System, Online Reporting Software
DSM	Diagnostic and Statistical Manual for Mental Disorders
DUMA	Drug Use Monitoring in Australia
ERRCD	Electronic Recording and Reporting of Controlled Drugs
IASP	International Association for the Study of Pain
IDRS	Illicit Drug Reporting System
IDU	Injecting drug use(er)
INCB	International Narcotics Control Board
MSIC	Medically Supervised Injecting Centre
NDARC	National Drug and Alcohol Research Centre (Australia)
NDS	National Drug Strategy
NDSHS	National Drugs Strategy Household Survey
NIDA	National Institute on Drug Abuse (USA)
NSP	Needle and Syringe Programs
OST	Opioid substitution treatment
OTC	Over-the-counter
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PGD	Prenatal genetic diagnosis
PO	Pharmaceutical opioids
PWID	People who inject drugs
SAMHSA	Substance Abuse and Mental Health Services Administration (American)
SUD	Substance Use Disorder

Drug Table

Prescription Status	Chemical name	Brand name	Colloquial terms
Prohibited substance	Diamorphine		Heroin, gear, junk
Prescription required	Oxycodone	OxyContin	Oxy
		Endone	
		OxyNorm	
	Morphine	MS Contin	
	Methadone	Methadone	Done
	Paracetamol and codeine phosphate	Panadeine Forte	
		Tramadol	
Available without prescription		Panadeine Extra	
		Nurofen	
		Nurofen Plus	

Abstract

The 'misuse' or 'abuse' of pharmaceutical pain medications is of growing interest among medical practitioners and has received increasing media attention over the last decade. Concerned with the health harms of non-medical consumption, medical and media attention has focussed on the potential to 'abuse' and become 'addicted' to pharmaceutical opiates. This thesis seeks to contextualise this emerging discourse of pharmaceutical 'abuse' within the social and political histories from which it has emerged. It is divided into two parts: the first addresses the discursive construction of painkiller (ab)use as it is articulated in dominant and expert accounts; the second part provides an empirical investigation that draws on the lived experience of those who actually engage in non-medical consumption.

This thesis critically analyses expert knowledge by asking how it constructs substance use, addiction, medical authority, the body and pain. It canvasses history, research and policy to articulate how dominant understandings of drug consumption and pain shift over time and within different contexts. The thesis outlines the way official accounts of drug consumption not only describe but also constitute non-medical consumption as a 'social problem' for policy intervention. It articulates how research about non-medical consumption often conflates a range of levels of drug consumption and can exaggerate its relationship with criminality. This increased criminalisation of painkiller consumption in policy and research is juxtaposed with a social context in which the definition of pain has begun to

encompass a broader range of human experiences. Broadening definitions of pain have contributed to increased cultural expectations about the therapeutic potential of pharmaceuticals.

The narratives and life experiences of people who engage in non-medical consumption are also explored. An empirical investigation in the thesis builds on qualitative traditions of drug research that indicate that drug use is a social practice inseparable from the context in which drugs are consumed. It reveals a range of practices that are not limited to 'abuse' and which occur in everyday contexts often at a distance from the criminalised image of policy and research accounts. Pain medications are an ideal complement to everyday cycles of restraint and release. This also extends to people who use opiates to treat chronic pain and who use medications for recreation. Analysis of interview data indicates that neoliberal and commercial discourse, which argue for individualised modes of medication consumption, are in tension with official accounts that posit the need for the strict control of opiates and those who consume them.

The work conducted in this thesis demonstrates that painkillers are intermediary objects that slip between the categories of legal and illegal, medical and non-medical, and moral and immoral, depending on the context of consumption. For those who use these medications, an intimate relationship between pleasure seeking, health practice and productive citizenship appears to dominate motivations for consumption.

Chapter One – Introduction

Pain is a frequent human experience. The sensation that accompanies bruised or torn flesh is instantly recognisable. The stress of a busy day and the painful throb of a headache are a common part of contemporary life. The way people relieve pain is almost as recognisable. It usually comes in the form of a pill, bought over-the-counter (OTC) or prescribed by the doctor. *Nurofen* and *Panadol* are household brands that can be found in most handbags and briefcases, kitchen cabinets and staff cupboards alike. Those who have been admitted to hospital, or visited a friend or family member there, will be familiar with the catheter drip of *morphine*. Once discharged, the take away prescription is usually *OxyContin* or *MS Contin*. Like pain, painkillers are a mundane part of everyday life.

Recently however health practitioners have expressed growing concern about the ability for painkillers to be ‘abused’. Reports about gastric ulceration and dependence on OTC codeine-containing medications like *Nurofen* (codeine and ibuprofen) have appeared in the medical literature (Dutch, 2008). The use of prescription pharmaceuticals has also been raised as a concern among health practitioners. Internationally, reports of illicit painkiller ‘abuse’ have emerged in Missouri (G. Harris, Hodges, & Snively, 2002) rural Kentucky (Tunnell, 2005) and California, among others areas (Whelan, Asbridge, & Haydt, 2011). Use of colloquial terms like ‘hillbilly heroin’ have reimagined *OxyContin* in the image of the urban ‘junkie’ that has haunted North American drug research for decades (Acker, 2002). It has also inspired a succession of documentary films (Carney, 2010) and

autobiographical books (Lyon, 2009; Stein, 2009) devoted to telling the story of 'normal' people who use this 'dangerous drug' and have become 'addicts'.

Media reporting about painkiller and OxyContin (the brand name for synthetic opioid oxycodone) use in Australia draws close comparisons to the US context. A 2008 piece from the *Australian Broadcasting Corporation (ABC)* reports anecdotal evidence that, for those seeking an opiate in street-based drug markets, 'hillbilly heroin' has become more popular than heroin itself (Edwards). In a March 2011 report in the *Sydney Morning Herald* oxycodone products are referred to as '*legal heroin*' and concerns are raised about the way prescribing physicians may be contributing to the criminal networks of the drug trade (Duff & Lane). In 2014 *The Daily Telegraph* reported that the Prime Minister and NSW Police Commissioner had been warned by US authorities of the possibility of a 'flood' of 'hillbilly heroin' into the country (Benson). Painkillers like OxyContin have come to be incorporated within 'war on drugs' rhetoric, often positioning them as illicit products.

Ironically, the appropriation of medications for purposes other than they were prescribed for has been an important source of innovation for pharmaceutical companies. Race reports that "Viagra (sildenafil citrate) came across its current application when male participants began to report more amorous effects; a possible treatment for some of the symptoms of multiple sclerosis came to light at Botox parties, of all places; even thalidomide recently returned to the market with new dermatological applications" (2005). Moreover, the economic agenda of the pharmaceutical

industry and its role in, what has been referred to as ‘disease mongering’ (promoting the proliferation of disease categories for the purpose of profit) have been recognised by both the medical and sociological literature (Peter Conrad & Leiter, 2004; Moynihan, Heath, & Henry, 2002).

More generally, research suggests that the informal sharing and non-prescriptive use of medication is relatively common, and such practices take place frequently in familial and friendship contexts that are very different from the criminal drug networks discussed in media reports. While such practices are not endorsed by medical authorities, they are consonant with discourses of patient self-care and self-management promoted by health authorities and advertising. Pharmaceutical funded lobby groups argue for greater individual freedom for access to medications. The commercial push towards self-care is complementary to the emergence of the patient’s rights movement and notions of health ‘consumers’ (Australian Self Medication Industry, 2014). Neoliberal notions of individual freedom and purchasing power have been presented as part of a campaign by commercial and consumer groups to make medications available for consumption outside of the strict control of the medical profession.

This thesis examines the emergence of a discourse of ‘abuse’ surrounding non-medical consumption of pain medications and its tension with neoliberal and consumer discourse. These tensions will be drawn out through reflection on current research, media, and public debate as well as the lived experience of a mixed group of people who (ab)use painkillers and were interviewed by the author. Through conceptual analysis and empirical investigation this thesis argues that non-medical painkiller consumption is

more contested and disparate than American terms like 'hillbilly heroin' imply. While aspects of the archetypes of the desperate drug user who will 'use anything' or the 'naïve' user who runs into trouble with pain pills certainly feature in this thesis, they are by no means the whole story.

The work and approach conducted in this thesis sit within critical drugs research located at the intersection of cultural studies, sociology and criminology. These disciplines have explored the social construction, political economy and discursive formation of drug use. This introduction will set out the theoretical background on which the thesis is based. It will explore the social construction of the term 'painkiller' as well as provide a summary of relevant social theory related to medical discourse and consumption in late-modern societies.

What is a painkiller?

In simple terms, 'painkiller' refers to a variable range of pharmaceuticals that are prescribed or used for the relief of pain (Dingelstand et al.,1996). However it is important to recognise that the categorisation of a drug as a painkiller is highly context dependent, since it often includes controlled substances that are illicit unless prescribed. This necessarily positions medical practitioners and authorities as the crucial mediating agency in access to pain relief. The construction of a drug as a painkiller is therefore a social and legal process that is frequently elided in medical and scientific accounts.

The medical literature describes painkillers as a group of drugs that act on the peripheral and central nervous systems to achieve analgesia – relief from pain. This drug type is also commonly referred to as analgesic medication. Most analgesic medications are at least partial-synthetic formulations derived but not directly extracted from the opium poppy. Analgesic medications available in Australia include paracetamol, ibuprofen and, the most popular, opioids. Morphine is the major psychoactive chemical in opioid-based substances and is found in both its prescription (oxycodone, hydromorphone, etc.) and OTC (codeine) variations. The chemical structure of opioids are not however limited to analgesic medications. The illicit drug heroin is also considered an opioid because it shares a similar chemical structure to many prescription analgesics and produces similar mechanisms of action (Robson, 2009).

Medical accounts of pain relief draw heavily from scientific classifications based on the drug's chemical structure or effect on the body. The typical scientific taxonomy of drugs based on chemical structure will include the following categories: opioids, sedatives, stimulants, cannabinoids, hallucinogens and volatile inhalants. The opioid is the most common drug-type used for the relief of pain, although sedatives have a long history in pain relief (Hughes, 2008: 37). Cannabinoids have also been presented as having pain-relieving potential, particularly in the case of chronic pain or recovery from cancer (Holdcroft et al., 1997; Iversen & Chapman, 2002). It is however important to recognise that not all drugs fall clearly into one category, nor do all drugs in one category produce the same mechanisms of action. For instance, alcohol produces both sedative and

stimulant effects on the body (Hendler et al., 2013). Moreover, knowledge about the physiology of the human body is limited in ways that make it difficult to account for a drug's impact on multiple parts of the brain (Degrandpre & White, 1996).

Given such limitations, classification systems often end up relying on "social categories like legality, therapeutic potential and potential for abuse" (Keane, 2002). Consequently classificatory structures can ignore the chemical and functional similarities of some drugs in favour of their social construction. Social constructions like legality and therapeutic potential are the main way in which painkillers are categorised, both in lay and professional contexts. One of the implications of this is that symbolic distance is often placed between licit and illicit forms of the same drug type.

The distinction made between pharmaceutical analgesic and illicit drugs also involve elements of the regulatory systems that control the international supply of opioids and other drugs. From a succession of international treaties during (and before) the 1960s, the International Narcotics Control Board (INCB) classified different drug formulations into a system of categories called schedules. Each schedule requires different levels of reporting to the INCB. This structures the availability of the substances classified as opioids and their use for the treatment of pain. Domestic legislation provides its own system of schedules for the medical and indeed criminal regulation of opioids, which have both licit and illicit use according to law. These regulatory and legislative structures borrow from and reproduce medical discourses that construct certain drugs as therapeutic. However international law does not determine domestic

criminal law or medical conduct. Instead policies within nation-states are partly structured around international regulation and an increasingly globalised medical profession.

The subjective experience about what may constitute relief from pain also considerably expands the colloquial scope of the term painkiller. For example, the 'painkilling' effects of alcohol are recognised in culturally entrenched forms of drinking to 'kill the pain' or 'numb the pain', although alcohol is not medically prescribed for pain relief. A substance's status as 'medication' is therefore intricately tied to its role in a medical narrative of treatment.

A painkiller can be defined in different ways in different contexts. Analgesic medications are understood as therapeutic technologies because they are distinguished from their more stigmatised (opioid) counterparts. A complex combination of legislative structures, professional practice and even commercial interests (Blackett & Robins, 2001; Fisher, 2003) frame the way particular substances are either used in medical treatment or ascribed a criminal classification. The 'painkiller' is best understood as a particular enactment of legislative, pharmacological and discursive frameworks surrounding medical practice. The way painkillers are consumed, and how this is structured by the conditions of contemporary society are a key concern of this thesis. The sections that follow will explore the how the conditions of late-modernity shape medical discourse and consumption practices.

Medicine and Medicalisation

Since the 1950s sociological research has been interested in the influence of the medical profession within society. Research interest in medicine has informed the establishment of a range of subdisciplines: the sociology of medicine, sociology of health and illness, sociology of the body, as well as health anthropology and medical anthropology. One of the key features of this interest in medicine and the medical profession has been the notion of 'medicalisation'. The term medicalisation refers to the process by which human problems become defined and treated as medical conditions (Conrad, 2008).

The medicalisation thesis was originally developed during the 1950s and '60s in response to the rapid growth of the medical profession at the time (Lupton, 1997). Social researchers began to notice that the medical perspective was encroaching on a range of 'deviant' social behaviours, which were increasingly the subject of medical intervention. The term's emergence in social theory came largely as a rejection of the conservative structural functionalism that dominated sociology at the time: it was intended to "challenge and subvert the power of the medical profession" (Lupton, 1997: 95). Much of its earliest uses in sociology developed a Marxist critique of the way the medical profession acted as an agent of social control (Illich, 1976).

During this period, feminist scholarship developed a related and important critique of the medicalisation of the female body (Ehrenreich & English, 1973, 1978). Psychiatry in particular was accused of pathologising

drug consumption as a 'female problem' (Cooperstock, 1976). Higher rates of women seeking physician services, as well as being prescribed and using more medication, led feminist scholars to the conclusion that conceptualisations of "drug taking behaviour be based on a broader perspective than that of purely individual considerations" (Cooperstock, 1978). Women's experiences of oppression were either ignored (prompting some women to 'self-medicate') or individualised as symptoms of ill health/emotional instability. A feminist account of medicalisation thus linked women's use of substances, both licit and illicit, to the widespread pathologisation of women and their bodies.

Analysis of the pathologisation of mental states became an influential strand of critical medicalisation scholarship, with a disparate group of scholars forming, what has come to be known as the anti-psychiatry movement. The work of influential thinkers such as Szasz (1961, 1970) and Foucault (1973, 1988) is regarded as an important precursor to the anti-psychiatry movement (Dain, 1989). The anti-psychiatry movement focused on the social control elements of the psychiatric profession and argued that medical discourse was being used to disguise moral judgments about the behaviour being 'treated'. Pearson noted that many forms of deviant behaviour were becoming the subject of social control through their diagnosis as mental illness: "Psychiatrists would not talk of 'condoning' the spots of measles or the fever of pneumonia. The word 'symptom' is a deception which conceals a hidden moral judgment about the propriety of homosexual [and other apparently deviant] conduct" (1975: 26).

During the 1980s American sociologist Conrad (1980) outlined how a range of 'deviant' behaviours, including alcohol and opiate consumption, were becoming the subject of medical intervention. At the same time Crawford (1980) observed a heightened ideological concern about health in industrial societies, describing how an age of 'healthism' was informing the medicalisation of everyday life.

Since the introduction of medicalisation as an analytical tool social science researchers have indicated a need to diversify the concept in response to changing circumstances. Notable attempts to capture nuanced elements of medicalisation include the technological focus of 'biomedicalisation' (Clarke et al., 2003), 'geneticisation' in the construction of mental illness (Phelan, 2005) and the importance of market mechanisms highlighted with 'pharmaceuticalisation' (S. E. Bell & Figert, 2012). The concepts developed in accounts of pharmaceuticalisation will be particularly relevant to the analysis in this thesis.

One of the central arguments surrounding a shift towards a pharmaceuticalisation framework is the significance of industry entanglement with modern health care. Much controversy has for instance surrounded the relationship between the pharmaceutical industry and prescribing physicians (Wazana, 2000). US studies have indicated that "interactions with the industry were found to start as early as medical school and to continue well into practice" (Wazana, 2000: 375). In 2004 Conrad and Leiter argue that:

Until the last decade or so, sociologists rarely examined medicine as any kind of marketplace. But it is becoming clear that, with the development of managed care, corporatized medicine, and the rise of the biotechnology industry, medical markets are increasingly important in the analysis of health care. (2004: 160)

Though the regulation of 'medical markets' remains ultimately with the medical profession, thus operating outside the conditions of traditional 'free markets', recent shifts have seen consumer demand play a leading role (Conrad & Leiter, 2004; Williams, Gabe, & Davis, 2008).

However, the medical profession, and increasingly the pharmaceutical industry also assume a determining role in what is considered a medical problem appropriate for pharmaceutical intervention. There are professional and commercial interests involved in what is given medical attention and what medications are made available for treatment. Thus the way medical knowledge formulates health and illness is not a self-evident elaboration of the human condition. The conditions of modern society produce a range of effects on the human subject that are only selectively ascribed a medical label. Medicalisation scholarship thus provides important tools to contextualise the social constructions and political economies that inform our culture's approach to the consumption of pharmaceuticals.

Consumption in late-modernity

Consumption is an important part of post-industrial society. People are encouraged by a wide variety of sources to purchase and enjoy a range of commodities (Ritzer, 2001, 2005). Advertisements from large companies are splashed over the cityscape of urban spaces and are increasingly embedded in on-line formats. Encouragement to consume is everywhere. There are however limits to consumption, and in the contemporary context 'proper' consumption is most often viewed under a framework of rational-medical discourse. The influence of the medical perspective in this respect is linked to enlightenment thinking about rationality and moderation (Reith, 2004). The structural components of modernity, including though not exclusively the influence of the medical perspective, thus frame the way people consume. This section will outline developments in the modern condition that inform contemporary approaches to consumption.

An important element of the industrial revolution in Europe and America towards the end of the nineteenth century was increased investment in ideal notions of capitalism, as well as secularism and rationalism. While Marx (1848) emphasized the role of production as a central organizing component of industrialism, a range of social theorists have since observed a greater emphasis on consumption in modern societies (Horkheimer, Adorno, & Noerr, 1944). Social theorists have noted the increased role of consumption in the enduring influence of the capitalist economic system (Ritzer, 2014).

Another key feature of modernism is enlightenment thinking and the prominence it places on the liberal subject. Liberalism has a long history in Western thought, building on social movements in the eighteenth century, and ultimately developing as a coherent political concept (classical liberalism) towards the middle of the nineteenth century (Mille, Vandome & McBrewster, 2009). Liberalism centers on issues of freedom: it declares that subjects must have equal and full access to free choice in their lives in order to be able to express and be themselves (Kelly, 2005). The consumption of knowledge and of commodities is however always filtered through processes of socialisation involving external structures such as class, race and gender. The social conditions that impede choice are therefore seen to compromise the autonomy of the individual and are largely regarded as oppressive. In much liberal philosophy there is a strong emphasis on the role of the state in ensuring the conditions of society allow for freedom of choice. The ideal of the freedom to consume is thus also central to the formation of the liberal subject in modern capitalist societies.

There is however a range of limitations to the liberal philosophy that should be noted. Liberalism assumes that its subject is a rational agent whose choices, given the appropriate social condition, can be made independent of the social context in which they occur. For instance, researchers have demonstrated that it is problematic to assume that everyone in our culture has equal access to all forms of information about health, or equal capacity to act on knowledge about health (Benoit et al., 2010).

Liberalism is also an evolving tradition in Western thought. Over the past thirty years the concept of 'neoliberalism', has emerged as a prominent element of economic and social policy in many advanced capitalist societies. Like classical liberalism, neoliberalism espouses the ideals of freedom of choice. However for neoliberalism the freedom of the individual is the responsibility of the individual. In the context of health care neoliberalism demands a radically individualised subject that shifts the responsibility for health onto the individual (Petersen & Lupton, 1996). People are instructed to make 'healthy life choices' by being an 'informed consumer' of health products (Petersen et al., 2010). Unlike classical liberalism the neoliberal philosophy has tended to devolve the responsibility of the state for health and social welfare by placing the onus on the individual.

The development of neoliberal thought has emerged alongside other transformations in the modern condition observed by social theorists towards the end of the twentieth century. Contemporary theorists have emphasized a fracturing of the way people relate to modernist institutions. Beck (1992) argues that capitalist and medical institutions are less reliable as foundations of community and identity. For instance the workforce is increasingly casualised in advanced capitalist economies (Bauman, 2007) and medical authority is encouraged to be verified by 'doing your research' and 'getting a second opinion' (Germov, 2009). For Beck, and those who followed in a similar tradition such as Giddens and Lash (1994), risk societies are thought to be constantly concerned with potential future risk and thus operate in a mode of uncertainty. The terms 'post' (Baudrillard, 1998), 'high' (Giddens, 1991), and 'reflexive' (Beck, 1992) modernity have

also been used to describe similar transformations in the modern condition as:

an era that is characterized by restructuring of economic and labour market processes and the diversification and fragmentation of social, familial, and community relations. It is dominated by increased insecurity, flux, and risk in social life. (Reith, 2004: 230)

The fragmentation of the traditional structures of modernity are also thought to be implicated in increasingly individualised responses to problems that can largely be understood as socially produced (Bauman, 2001). This is particularly conducive to processes of responsabilisation endorsed by neoliberal discourse.

Foucault's work on governmentality in the 1970s has also been used to trace changes in modernity and its impact on issues of governance. Governmentality scholarship has broadly traced how "modern states [have] moved from rule by crude force to sophisticated governance based on (shaped) consent" (Ferlie, McGivern, & FitzGerald, 2012). This work has made significant contributions to the characterisation of the late-modern era as a period of fragmented identity politics and individualised self-discipline. Governmentality scholars have applied the concept to contemporary approaches to health. Observations about a trend towards neoliberalism in late-modern societies has prompted analysis about the state's retreat from healthcare, focussing instead on individual responsibility for health (Lupton, 2014; Woolhouse et al., 2012).

Governmentality scholarship has subsequently become influential in the analysis of the neoliberal governance of disease transmission (Fraser & Seear, 2013), overdose prevention (Moore, 2004), and supervised injecting sites (Fischer et al., 2004), among a range of non-drug related health practices (Petersen et al., 2010).

Beyond the governance of the late-modern subject, sociologists have also noted how certain forms of drug use can be conceived of as a response to the conditions of late-modernity. Lyng (1990) formulated the theory of edgework, which posits that some people derive pleasure from uncertainty and risk taking. Much of the early edgework literature focussed on the way practices like extreme sports (Jonas, 1999) and illicit drug use (Collison, 1996) are forms of resistance to the fragmented and uncertain circumstances of the conditions of modernity. Edgework scholars argue that these 'risk-takers' reappropriate the detrimental elements of uncertainty to 'take control' of risk, that they subvert the detriments of risk by deriving pleasure from it (Ferrell & Stewart-Huidobro, 1996; Holyfield & Fine, 1997).

While this approach forms an important part of edgework scholarship, an opposing, though not entirely irreconcilable tradition has also emerged to suggest that edgework is less an escape from, but rather an extension of the conditions of late-modernity (Lyng, 2004). Pointing to the centrality of the individual in negotiating the risks of modern life, scholars have suggested that edgework may be permissively encouraged by late-modernity.

The theoretical accounts discussed here provide a framework for analysing how consumption is used to negotiate the constant demand for

flexibility in the pursuit of ideal health and productive consumption. The next section will outline the structure of the thesis and its two Parts.

Structure of the Thesis

This thesis is divided into two parts. The first Part focuses on the official discourses that surround non-medical consumption while the second Part is largely concerned with the lived experience of those who use painkillers. This section will outline the structure of the thesis, providing a summary of each chapter and an overview of how they relate to one another. The first part of this thesis contains three chapters and focuses on forms of historical and discursive analysis. It asks how non-medical consumption is constructed by medical, political and commercial interests. Chapter Two discusses overlaps between the social and legal regulation of drugs in Australia since the turn of the twentieth century. The chapter draws on a set of historical case studies and conceptual discussions about drugs, their regulation and consumption. In particular, it outlines how political and expert knowledge has shaped the distinction between licit and illicit drugs. It also foregrounds how the strict legal control of substances deemed illicit have come under challenge from consumer and neoliberal cultures that promote self-autonomy and self-responsibility in medical consumption. This focus on individual choice and agency overlaps in important ways with discourses of health promotion and public health.

Following on the historical assessment of the cultural production of knowledge about drugs, Chapter Three provides a critical overview of medical and epidemiological literature and research on non-medical pharmaceutical consumption. It discusses how the prevailing terminology in the field pathologises everyday practices of pharmaceutical use and informal sharing, and conflates these practices with diversion into criminal networks. The chapter articulates how research about non-medical consumption also often conflates a range of levels of drug consumption and exaggerates its relationship with criminality. It articulates how these processes of pathologisation have constructed non-medical consumption as a major social and criminal problem requiring the investment of public funds in prevention and surveillance strategies.

In the final chapter of Part One, Chapter Four, the concept of pain is explored in detail. This chapter discusses the way general medicine approaches pain and the use of pain medication. It highlights the divergent ways in which pain, and particularly chronic pain, is understood and treated within different areas of medical practice. The chapter also explores the way in which the speciality of pain medicine understands pain, medication use and 'addiction'. Finally it explores the blurring boundaries between pain, anxiety and discomfort in late-modern consumer culture.

The frameworks surrounding cultural understandings of pain, the influence of neoliberalism and medical discourse developed throughout Part One are used to inform analysis of qualitative interviews with people who use pain medications in Part Two of the thesis. These chapters explore the way participants use pain medications to respond to a broadening definition

of painful human experiences, such as boredom, work-related stress, the social and emotional burdens of chronic conditions, as well as the stigma of drug dependence. Neoliberal notions of individualised consumption are also explored within the context of intense work and recreational release, as well as the way this informs health practice for people who live with marginalised social conditions. The way participants engage with and appropriate medical discourse when describing these practices is also a key point of analysis.

The first chapter of the second part of the thesis is Chapter Five. This chapter explores the role painkillers play in participant experiences of recreational and polydrug use. The chapter addresses the different ways in which people spoke about the use of painkillers to 'get off your face' and to 'feel numb'. It also discusses the use of painkillers to manage other forms of illicit intoxication in order to 'stay safe' and while 'on the comedown'. The chapter concludes with a discussion of the normalisation of recreational drug use.

Chapter Six discusses the use of painkillers to enhance everyday cycles of restraint and release in a 'work hard/play hard' dynamic. The chapter explores neoliberal notions of productive work and its encroachment on the lives of participants in this study. It discusses the way people use painkillers to manage their sleep, stay productive at work or while studying, as well as when taking care of young children. The chapter also discusses the way painkillers are used to enhance alcohol intoxication on the weekend after periods of intense work during the week.

Chapter Seven provides an in-depth analysis of the lives of two chronic pain patients, and a participant who suffers chronic emotional pain. The chapter outlines the three men's different experiences of pain management and the ways in which it has affected their life histories and life circumstances. The chapter discusses experiences of chronic pain and its association with dependent forms of drug use. It explores encounters with doctors and conversations about how they define problematic and 'addictive' consumption of painkillers.

Finally Chapter Eight addresses the limitations of frameworks of addiction for understanding non-medical consumption. It canvasses sociological perspectives on addiction and addresses concern about the pathologising and individualising components of addiction discourse. The chapter explores the lives of two participants who no longer use drugs. These life histories are used to highlight the way gender, class and medical discourse intersect to constitute addiction in different ways in the lives of different people. The chapter then looks at how qualitative data can complement epidemiological literature about transitions between kinds of opiates and to intravenous drug use. It also addresses the role of agency in the construction of the 'addicted' subject.

Part One – Discursive construction: Introduction

The first part of this thesis is primarily concerned with the discourses that comprise history, regulation and research relating to painkiller and other drug consumption. It articulates how accounts of drug consumption and pain shift over time and within different professional and policy contexts. This involves an assessment of contemporary literature and research within the historical contexts from which they have emerged. Much of the analysis in Part One traces historical developments in a range of professional and research fields, including main medicine, addiction science, epidemiology, alcohol and other drugs research, social science literature, and social theory. The way these accounts relate to the development of policy and its relationship to public opinion/perception of drugs are also discussed.

The analysis conducted in Part One of the thesis applies the frameworks developed in critical drugs scholarship to an assessment of key policy and research documents related to non-medical consumption. This analysis centres on the way social research perspectives have developed a robust understanding of the social construction, political economy and discursive formation of drug use in a range of context. Throughout Part One of the thesis these frameworks are developed through an exploration of the social, political and discursive formation of non-medical consumption. This includes an examination of the social history of drug regulation in Australia, a critical analysis of research accounts about painkiller ‘abuse’, as well as an assessment of the development of medical and social understandings of

pain. This introduction provides a short history of critical drugs scholarship and the type of concerns it brings to an analysis of drug consumption, before discussing the specific ways in which the analysis of history, policy and research was conducted throughout the first Part of the thesis.

Critical drugs scholarship

Social research perspectives have a long history exploring the relationship between medical discourse and drug consumption. Social science research in sociology and criminology has informed the empirical assessment of drug use and the development of contemporary critical drugs scholarship. This section will outline a set of key literature that provides the conceptual tools for analysis of policy and research.

The social construction of drug use is an important element of critical drugs scholarship. Research about social deviance became foundational to the lasting tradition of the University of Birmingham's Centre for Contemporary Cultural Studies (CCCS) (Cohen, 1972; Hebdige, 1979), as well as the critical criminology movement (Cohen & Young, 1973; Taylor, Walton, & Young, 1973). It is within these traditions that critical scholarship has developed scepticism of the notion of opiates (and other drugs) as 'drugs of abuse'. This is not to deny that people may experience problems with drugs, but to seek to situate that experience within its social and cultural context, which includes the labelling and stigmatisation of people who use drugs within political, media and medical discourse.

The critical tradition of drug research can be traced to Young's *The Drug Takers* (1971), which argued that the practices of people who used drugs formed a system of 'subterranean' values that closely resemble the conventional value systems of 'late' and 'post' industrial societies. Young observes that the British citizenry "must produce in order to consume, and consume in order to produce. The interrelationship between formal and subterranean values is therefore seen in a new light: hedonism, for instance, is closely tied to productivity" (1971: 128). Such an account demonstrates that particular kinds of drug use are constructed to be hedonistic because of their relationship to socially desirable notions of productivity. The social construction of drug use is thus necessary to consider when discussing how particular kinds of pharmaceutical consumption are constructed to be medical and others non-medical.

By the 1980s the social construction of drug use had become an established area of study. Rather than continuing to reiterate the social construction of drug use, researchers began to focus on the elements of that construction. Taking their lead from Zinberg's influential study with heroin users, *Drug, Set, and Setting* (1986), qualitative drugs research began to focus on the 'social context' of drug use (Rhodes & Moore, 2001). Zinberg's work provided one of the first, and certainly the most influential theoretical frameworks of drug consumption that incorporated considerations of the pharmacological, psychological and social (Moore, 1993). Drug researchers began to emphasise how diverse contexts produce particular forms of drug taking. For instance, research turned its attention to the lives of sex workers in a street-based drug market in Brooklyn (Maher, 1997), and to street-level

crack¹ dealers in the 'ghetto' neighbourhood of East Harlem (Bourgois, 1995). These kinds of political economies of drug consumption describe how the constructions of particular forms of drug use are embedded in particular social contexts.

Poststructuralist contributions from cultural studies (and related disciplines) have built on the social and political accounts of drug use discussed thus far by highlighting the role of discourse. Poststructuralism forms an important part of the theoretical framework of this thesis because it helps to explain how social constructions and political economies can be moulded and transformed by the discourses used to articulate them. In *Pleasure Consuming Medicine* (2009) Race traces how particular kinds of discourses about pleasure, consumption and medicine converge in different ways in different contexts. In contrasting the discourses that surround recreational drug use at dance parties and HIV prevention among gay men Race observes that "a drug is not a thing - or not only. Its safety and specific effects vary according to complex assemblages of composition, interaction, timing, behaviour, history, digestion, inscription and affect" (2009: 54).

Following from the notion that a drug's effects are contextually contingent, poststructuralist drug scholarship has made important contributions to critical perspectives on 'addiction'. In particular poststructuralism has maintained scepticism over the notion that addiction is a single knowable entity that medicine can simply discover and treat. Poststructuralism tells us that addiction is a historically and culturally

¹ Crack is a freebase form of cocaine that can be smoked.

contingent phenomena that is the product of a diverse set of social, political and discursive formations (Redfield & Brodie, 2002).

Keane's *What's Wrong with Addiction?* (2002) is a particularly significant work in the field that problematises cultural formulations of drug dependence as 'addiction'. Keane's work identifies the various conceptualisations of 'drug addiction' found in, for instance scientific classifications of drugs, pain medicine literature (Keane & Hamill, 2010), psychiatric diagnostic practice (Fraser, Moore & Keane, 2014), and the self-help and 12-step philosophies (Keane, 2002). The discursive element is most clearly demonstrated in her exploration of the expansion of addiction discourse to forms of "strong attachments, powerful urges, preoccupation and social harm" (Keane, 2002: 63) that are in no way limited to drug use. Referring to the emergence of food and sex 'addictions' in psychiatric and popular discourse, Keane asks:

Can food and sex act like psychoactive drugs and alter people's psychological and physiological functioning? Or are these addictions simply moral judgements about 'bad' ways of eating and having sex dressed up in the language of disease? If addiction is not determined by a particular property of the object of addiction, as the recent proliferation of addictions suggests, does this mean that everything is potentially addictive? (Keane, 2002: 5)

Of course Keane's goal is not to determine whether 'addiction' is *really* a property of the drug or a generalisable category of disease. Instead her work

acknowledges that “our tools for making knowledge help to constitute the very phenomena under observation” (Keane, Moore, & Fraser, 2011: 875).

Official discourse

The study conducted in Part One unpacks the assumptions behind ‘official’ understandings (Burton & Carlen, 2013) of non-medical consumption as a ‘social problem’ (Bacchi, 2009). It examines the institutional authority and expert purchase of the ‘official discourses’ of medical and political knowledge about drug consumption. This approach draws from poststructuralist traditions of discourse analysis that critique the way the subject of policy and research is presented as fixed or preexisting (Barker & Galasinski, 2001). The analysis conducted does not simply treat expert perspectives and policy accounts as a mode of addressing drug use. Instead it explores how the discourses that make-up ‘official’ understandings of non-medical consumption shape the phenomena being articulated.

This analysis was carried out through close reading and conceptual analysis of key archival material, policy documents and research literature. Broad developments in the approach to and meaning of opiate and other drug consumption were surveyed in a range of relevant material (Saukko, 2003). Shifts in the significance of drug use and medical authority over pharmaceutical consumption were drawn out through analysis of media, policy and political documentation. Research on the social and legal

development of drug policy and social welfare was used to inform the interpretation of historical documentation.

The project also involved critical analysis of a variety of fields of expert knowledge. Key documents influential across policy and research were targeted for their implications for the construction of non-medical use. For instance the American Psychiatric Association's (APA) Diagnostic and Statistical Manual for Mental Disorders (DSM) is analysed for its impact on discourses of anxiety and substance dependence. Policy documents and material from key institutions were also explored. The work of the US based National Institute on Drug Abuse (NIDA), as well as Australian institutions such as the National Drug and Alcohol Research Centre (NDARC) and the Australian Institute of Criminology (AIC) were surveyed for their contribution to and construction of debates about non-medical use and addiction.

Once relevant organisational and institutional documents were identified, these documents were analysed through a combination of preliminary and close readings (Bowen, 2009). Aspects of content analysis and thematic analysis (Silverman, 2013) were used to draw out significant phrases, terminology and modes of knowledge. As noted above, the work of poststructuralist and critical drugs scholars (Keane et al., 2011; Petersen, et al., 2010) was drawn on to frame the interpretation and analysis of this material.

Utilising the frameworks outlined here Part One of the thesis will seek to describe the relationship between the social construction, political economy and discursive formation of the non-medical consumption of

painkillers. Drawing on contemporary critical drugs scholarship it will elaborate on the meanings that come to be attached to non-medical use in and through a range of 'official discourses'.

Chapter Two - Regulation of drug consumption in Australia

At the outset of the twentieth century medical regulation and legal prohibition had yet to become a significant part of Australia's approach to 'drugs'. As such there was little formal differentiation between legal and illegal opiates or medical and non-medical ways of consuming such substances. Today opiates are tightly regulated through systems of international and domestic law, and their use is at the centre of debates about medical and health practice in most late-modern societies. These changes are often attributed to a growing medical (and scientific) awareness of the harmful potential of particular variations of opioid, in combination with the emergence of what has been framed as a 'social problem' of significant concern. However the social history of Australia's approach to drugs, and opiates in particular, paints a much more complex picture. This chapter traces the emergence of influential medical and political knowledge about drugs and its consequences for legislative regulation and health policy. Using a series of historical case studies the chapter articulates how political and expert knowledge has shaped the distinction between licit and illicit drugs.

Australian attitudes to drugs have always been highly influenced by the international context, and especially the policies and politics of the United States (US). The establishment of most Australian drug legislation has also been largely focussed on opiates and other analgesics, which forms the basis of the historical investigation throughout the chapter. It begins

with a discussion of the introduction of legislation targeting the Chinese population of Australia during the early twentieth century. Emerging interest in the physiology of 'addiction' among American researchers in the 1920s were influential in the development of US drug policy, which also set the tone for international debates about drug regulation.

These events initiated changing approaches to drugs that were seized upon by the medical profession and political establishment in order to expand mechanisms of social control. The increased prominence of medicine throughout the twentieth century is explored with particular interest. Subsequent politicisations of medical knowledge about drug use are explored in a range of examples, none more significant than the absolute ban placed on heroin in 1953. Establishing influential governing frameworks about 'good' and 'bad' drugs, this event has defined much of the meaning-making processes around opiates since its implementation.

Within this context the chapter then explores the diversification of the cultural meaning of 'drugs'. It interrogates the growing sense of 'safety' attached to legal drugs, especially in relation to the 'danger' associated with illegal drugs. The liberalisation of alcohol legislation during the 1950s is illustrative of the symbolic significance of the state sanctioning of certain drugs as 'safe'. The implementation of the Pharmaceutical Benefits Scheme (PBS) provides an example of the normalisation of pharmaceuticals in medical practice in Australia. Use of OTC headache powders in the 1950s and '60s is however used as an example that challenged closely held cultural narratives about the 'safety' of pharmaceuticals.

The chapter then explores aspects of the economic and political circumstances of advanced capitalist societies, and the impact this has had on problematic drug consumption. Developments in global approaches to economic management and welfare policy are raised as important precursors to the neoliberal philosophy and its encroachment on aspects of health policy. The chapter articulates how a trend towards neoliberal economic policies has compounded the criminalising effects of prohibitionist oriented drug legislation. The US 'war on drugs' and its impacts on Australian policy and policing practice are also explored. Finally the emergence of the harm minimisation movement provides an important example of contestation between models of medical and self-regulation.

'Opium suitable for smoking'

Established in the early twentieth century, some of the first laws restricting the use of drugs in Australia were aimed at 'opium suitable for smoking' (Brereton, 2000). The reasons opium smoking was specifically 'targeted' in early drug legislation in North America and Europe is still contested in historical research. The Opium Wars in the nineteenth century is however a requisite starting point. The culmination of diplomatic and trade disputes between the Chinese Quing Dynasty and the British Empire, the Opium Wars occurred between 1839-1842 and 1856-1860. It was during these periods that opium smoking was introduced into Chinese culture by the British. The smoking of opium was however viewed by the Chinese as a practice of the

underclass (Hamilton, Kellehear, & Rumbold, 1998). In North America the completion of the trans-America railroad in 1869 coincided with an influx of Chinese migrants in a time of recession, prompting a cultural backlash that included the vilification of opium smoking.

It was these political and economic conflicts, masked by issues of race, which eventually resulted in legislation about opium smoking in the early twentieth century. The international community played a key role in the development of early drug legislation in Australia, with the Commonwealth imposing an absolute ban on the importation of 'opium suitable for smoking' in 1905 (United Nations Office on Drugs and Crime, 2008). Subsequently, State governments were pressured to introduce legislation criminalising the manufacture, traffic, possession and use of 'opium suitable for smoking' (Carney, 1981).

While there were important political and economic dimensions to the Opium Wars and the subsequent banning of opium smoking, the issue of race was central. For instance, similar legislation restricting opium use among Aboriginals had already been implemented in Queensland's *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* (Purdie, Dudgeon, & Walker, 2010: 30). The legislation targeting opium smoking was also fundamentally racialised because it targeted a form of drug consumption associated with Chinese migration while ignoring the widespread use of other opium products that were popular among white-Australians. One of the most popular health products during the late nineteenth century and early twentieth century was called Laudanum, and it was excluded from this early

legislation. Widely used by white-Australians Laudanum was also known as Tincture of Opium.

Perhaps the most infamous opiate-based drug, heroin, was also exempt. At the time heroin was a popular, easy to administer drug that was available without prescription (Duster, 1970). Physicians of the time thought of heroin as being three times as potent as morphine, entirely nonaddictive (Ray, 1978), and an effective cure for 'opiate addiction': in fact "it was named Heroin for these 'heroic' properties" (Conrad & Leiter, 2004: 121).

Though the pharmacology of opium smoking and the consumption of other opium-based products is largely identical, the practices were demographically distinct (Manderson, 2005). Historians have observed the discriminatory nature of legislation targeting 'opium suitable for smoking'. In Australia a significant element of opposition to opium smoking came from Chinese merchants, clergyman and Chinese newspapers. Playing on the fears of 'White-Australia', opposition to opium smoking often took on a sexual tone. Anxiety over keeping the 'purity' of white-Australia perpetuated a perverted figure of the 'Chinaman', constantly depicted as a "trafficker in young white women, and opium as the device by which the sexual inhibition or revulsion of young girls towards the Chinese could be trepanned, weakened, or overborne" (Manderson, 2005: 45). During the late nineteenth century there were a number of reports commissioned by various government bodies which sought to "give some idea of the prevalence of vice and depravity induced by this enslaving and degrading practice" (Sydney City & Suburban Sewage and Health Board, 1875).

Antagonism towards opium smoking was not limited to Chinese newspapers. Anti-Chinese sentiment informed an entire policy agenda during the early twentieth century, with opium smoking forming what Manderson refers to as one “tentacle of the octopus” (Manderson, 1993: 15). Perhaps the most significant example of racialised government policy included the restrictions placed on Chinese immigration, like those found in the *Immigration Restriction Act 1855 (Vic)*, the *Chinese Restriction and Regulation Act 1888 (NSW)*, and the *Immigration Restriction Act 1901 (Cth)*. Discriminatory immigration legislation was often justified on the grounds of the financial security of white miners (Lake & Reynolds, 2008).

As part of a push from the Chinese elite, and a social anxiety about maintaining ‘White-Australia’, a range of discriminatory government policies were introduced in the early twentieth century (Dyster & Meredith, 1990) that sought to deter aspects of Chinese culture within Australian migrant communities. Part of this series of discriminatory policies included legislation about the smoking of opium because it was associated with the Chinese population. A web of politically motivated, racialised discourses informed shifting approaches to drug regulation in Australia. Legislation targeting practices common among Chinese migrants reveals little scientific motivation for early legislative structures for opium. Indeed such legislation illustrates the influence of the political forces that have long informed ‘official’ distinctions between kinds of opiates, the way they are consumed and the people who consume them.

Addiction, medicine and drug policy

Another driving force behind the push to regulate the international supply of opiates was the emergence of 'addiction' in American research. During the 1920s some of the earliest research on the physiology of addiction was conducted on monkey colonies ('junkie monkeys'). Campbell has noted that these research subjects were purposefully chosen as they were best positioned to perform a version of drug dependence that appealed to US funding bodies of the time. In order to avoid the perceived pitfalls of researching the pleasurable aspects of drug use, researchers "turned to animal models both to bracket desire and to place their research on the more objective ground sought by the NRC [National Research Council] Committee on Drug Addiction" (Campbell, 2007: 29). Psychiatric research with prison populations in the 1920s and '30s also appealed to the NRCs investment in 'drug addiction' as a criminal pathology.

The work of psychiatrist Lawrence Kolb played an important role in the development of early twentieth century medical models of 'drug addiction'. Among a set of six addict 'types' Kolb formulated a distinction between "normal persons who have become addicted accidentally or... through medical treatment" and people who have "immature, hedonistic, socially inadequate personality" (Kolb, 1962: 5-6). The moralising implication of distinguishing between 'normal' people who were the victims of medical misconduct and 'psychopaths' who were motivated by a hedonistic pursuit of pleasure has had a lasting impact in the addictions field. Kolb's later work with prisoners at a facility in Lexington Kentucky,

infamously known as the Lexington Narcotic Farm, also reinforced the notion that there is a clear distinction between the physiological and psychological elements of addiction.

The prominence of the physiological/psychological distinction in psychiatric research was partly a reflection of the notion that, at the time, addiction was largely thought of as an iatrogenic condition. Iatrogenesis traditionally refers to situations in which a patient has been harmed in the process of medical treatment or as a result of the negligence of a medical practitioner - iatrogenic addiction is “addiction caused in the course of medical treatment” (Acker, 2002: 29-30). Based on the assumption that most ‘normal’ people could be protected if opiate use in medical treatment was restricted, the psychiatric community advocated for expansions to the US *Harrison Act*, a piece of legislation originally designed to regulate and record the supply of opiates.

Kolb’s work on addiction and crime in the 1920s advocated that ‘drug addiction’ was a medical problem, and that treatment, not law enforcement was the solution. However, in the looming shadow of alcohol prohibition the American political climate was veering towards the banning of drugs. Expansions to the *Harrison Act* during 1920s and ‘30s meant the act became increasingly punitive (Conrad & Scheider, 1980: 124-125). Though Kolb and others in the psychiatric community advocated for a medical response to ‘drug addiction’, support for the expansion of the *Harrison Act* meant that, ironically, psychiatry played an important part in the institutional criminalisation of addiction.

The criminalisation of addiction in the US also had an influence on the way medical practitioners related to the 'addict' population. During the 1930s and '40s the American Medical Association were closely monitoring changes to the *Harrison Act* and had been vocal about its opposition to provisions that diminished the authority of the medical profession – through restrictions on medical authority to prescribe opiates. As judicial interpretations of the *Harrison Act* became increasingly punitive the demographic of 'opiate addicts' was shifting to be more clearly associated with young inner-city men who were increasingly seen as 'deviant' thrill seekers (Conrad & Schneider, 1980).

As the only profession to have legitimate access to opiates, the prescribing physicians became the only legal avenue to acquire the drugs that 'addicts' required. Throughout the 1930s and '40s sections of the medical profession became increasingly frustrated by having to act as gatekeeper to the 'thrill-seeker's drug:

physicians became increasingly wary of patients complaining of mysterious pains and demanding relief through drugs. As addicts became undesirable patients, the motivation to study the physiological mechanisms or human dimensions of addiction waned. (Acker, 2002: 62)

With the institutional criminalisation of addiction there was an increasing distance between the medical profession and the 'addict population' of the US. A growing number of people dependent on opiates began to turn to, and

eventually depend on, illicit markets for the supply of drugs like heroin (Conrad & Schneider, 1980: 127). As a result stigmatised images of the urban 'junkie' proliferated in American society throughout the middle of the twentieth century.

International frameworks for medical models of addiction echoed aspects of the American context. In 1957 the World Health Organisation (WHO) published a series of definitions relating to substance use. The first, addiction, emphasised the need for both physical and psychological dependence and the second, habituation, placed emphasis on only psychological dependence (Zinberg, 1986: 29-30). The distinction between 'addiction' and 'habituation' reinforced the notion that people who have become drug dependent because of recreational drug use were the real 'addicts'. In 1964, the WHO abandoned the term 'addiction' for 'drug dependence', though its definitions still emphasised an implicitly moral distinction between the physiological and the psychological aspects of addiction (Keane & Hamill, 2010: 55). These formulations of addiction and related terms linked closely with psychiatric research by Kolb and others who followed in a similar tradition. At the international level the physiological/psychological distinction functioned as justification for the demonisation of drugs like heroin and the stigmatisation of people who used it.

As a young nation Australia was often influenced by developments in the international community. After the implementation and expansion of the Canadian *Opium and Drug Act 1911*, the British *Dangerous Drugs Act 1920* and the American *Harrison Act 1914* international pressure was mounting

for Australia to implement similar policies of criminalisation. The Commonwealth intervened to impose further restrictions on the importation of opium (as well as other drugs including cocaine, marijuana, etc.), and State governments followed in similar fashion with laws criminalising heroin possession and use throughout the 1920s. Yet by the 1930s Australia was still “using 7.5 per cent of the world’s legal [medically prescribed] heroin supply” (Rowe, 2005: 108), which amounted to approximately three times that of the British (per capita) and nearly fifty times that of the United States (per capita) (Rolfe, 1989). However most of these prescriptions were for people who were dependent on opiates, and if the British and American contexts allow any insight, much of the ‘addict’ population at the time was still white, middle-aged housewives and doctors (Conrad & Schneider, 1980).

Unlike their American counterparts Australian physicians continued to medically maintain ‘heroin addicts’ well into the 1950s. While Australia lingered behind other developed nations in the banning of heroin, the Australian medical profession did place intense focus on reducing and regulating the ‘non-medical use’ of heroin throughout the first half of the twentieth century. Advocacy for the medicalisation of ‘addiction’ ensured that the medical profession could gain greater control over the prescription of heroin:

by defining *all* users of illegal drugs [such as heroin] as addicts, breaking the law itself became a sign of illness. Medical authority was therefore entrenched... the medical user had already acknowledged

medical power, and the non-medical user was sick by definition, and was therefore an appropriate subject of medical intervention... [and] legal controls. (Manderson, 1993: 103)

What was considered 'proper use' of heroin was increasingly left to the discretion of the medical expert, and the 'addict' label fostered an increasing convergence between the medical and legal control of people who used opiates in Australia.

The role of medical and political involvement

For the first hundred years of Australian history post-colonisation, drugs seemed to be an issue of very little significance to policy-makers. The development of foundational frameworks for Australian drug legislation were mostly produced in response to international pressure (Lupton & Najman, 1995). With the growing influence of British and particularly American conservative and Temperance movements in the nineteenth and early twentieth century, the regulation of the world's drug supply became a staple of international policy transfers and laws (Levine, 1993; Sulkunen & Warpenius, 2000). Tension between the passionate international pursuit of drug regulation and Australian ambivalence to the issue meant that, as drugs were too inconsequential an issue to risk the country's international standing, Australia repeatedly gave in to international pressure (Manderson, 1993).

While drug policy was initially accorded little significance by Australian lawmakers, its introduction did require a governing group of professionals to function as regulators. During the early twentieth century there were three main competing sellers of drug products: doctors, druggists (who were representatives of the patent medicine industry), and pharmacists. Rapid advances in medical science were among the most important factors involved in the rise of the medical profession as the foremost 'legitimate' provider of drugs. By the 1920s in the US and abroad "hygienic successes over germ-borne illness ushered in a new era of medicine that addressed chronic, non-infectious ailments including heart disease, kidney disease, and cancer" (Nadesan, 2008: 107). As developments in the addictions field demonstrate, the medical profession was the unequivocal victor in the right to regulate drugs.

The growing influence of medicine meant that medical knowledge was also becoming more specialised. A new division of labour in the medical profession meant that dentists, midwives and nurses, among others, became marginalised members of the medical community (Willis, 1989). Professions such as chiropractice became distanced from the increasingly prestigious arena of medicine, coming to reside instead under the less prestigious label of health-care. As the medical community gradually gained prescriptive authority over more and more substances, druggists and the patent medicine industry dissipated, while pharmacists were relegated to a dispensary role (Manderson, 1993). Moreover, by the 1940s the medical profession had not only won the authority to regulate drugs, but perhaps more significantly had become culturally accepted as the ultimate arbiter of

physical and mental health (Freidson, 1988). It was in this context that perhaps the most significant movement in social and political approaches to drugs occurred.

Legal heroin use in Australia almost doubled in the mid- to late-1940s from the already high rates of the '30s. This increase prompted international concern about Australia's attitude to heroin from the United Nations, and more particularly the US. Borrowing almost exclusively from the rhetoric of American proponents of prohibition, calls to ban the use of heroin, medically or otherwise, became more and more prominent in Australia. Despite no recorded deaths by heroin overdose in Australia between 1943 and 1953 (Wodak & Owens, 1996), and opposition from sections of the medical profession (Rowe, 2005), lawmakers placed a complete ban on heroin in 1953. The ban effectively criminalised everyone who had been using heroin at the time and the doctors who medically maintained their supply, while also guaranteeing the expansion of the criminal networks that had already emerged in response to tightening regulations. Similar bans on cocaine, marijuana and the like followed (Brereton, 2000).

By the 1960s Australian states were still complying with international pressure through increased sanctions, but for the first time they were doing so without objection. Politicians and bureaucrats started to see the potential for prestige and power in drug regulation, and, for the first time in Australian history lawmakers were behaving as if drugs mattered: "politicians saw votes in it, bureaucrats saw power and prestige in its administration" (Manderson, 1993: 141). A newfound interest in building a structure of Australian drug regulation saw a convergence of the interests of

the medical profession and government bureaucracies. This allowed for medical authority to inform a socially constructed distinction between 'licit' medical opiates (analgesic medications) and 'illicit' recreational opiates (heroin). The formulation of 'addiction' and its impact on drug policy is one important example of the impact of the overlapping interests of medical and political authority during the middle of the twentieth century. These overlapping interests also had consequences for the regulation of other drugs, such as alcohol.

The six o'clock swill

The fact that there was now political capital to be gained through public condemnation of drugs began to inform considerable transformations in the social significance of particular drugs, and those who used them. Since the early twentieth century alcohol had been the largest target of campaigns against the 'moral ills' of inebriate consumption. It was in this time that the Australian Temperance movement shifted from their longstanding position (since the 1830s) of advocating moderation to a strong lobbying effort for alcohol prohibition, which "at times came surprisingly close to success" (Manderson, 1993: 51). The vigour of Temperance campaigns for alcohol prohibition is at least partly thought to be reflective of the role alcohol played in domestic violence (Leonard, 2002).

Following influential campaigns from Temperance movements, South Australia voted, in a referendum in 1916, for six o'clock closing times for

pubs and hotels (Phillips, 1980). New South Wales, Victoria and Tasmania followed suit the very next year. The implications of the policy change were not however particularly congenial to the agendas of alcohol abstinence and prohibition. The new closing time initiated an exponential climb in alcohol consumption in the hour leading up to 6pm. The rush to get to the pub after finishing work and to consume as much as possible before it closed became a common part of Australian drinking culture, infamously known as the 'six o'clock swill'.

Faced with the tightening regulation of opiates and other drugs towards the middle part of the century, the powerful influence of Temperance movements and their conservative hold over alcohol regulation began to fade (Blocker, Faher & Tyrrell, 2003). The longstanding popularity of six o'clock closing times for bars and hotels soon began to wane (Phillips, 1980). By the 1950s NSW had moved to ten o'clock closing times, and Victoria and South Australia followed in the 1960s. With the decline of Australian Temperance movements alcohol consumption became less associated with the determined drunkenness of the era of the six o'clock swill (Room, 2010).

As Australia moved into the second half of the twentieth century, the medical profession also cooperated in the process of deregulating and destigmatising alcohol. References to alcoholism were increasingly deployed in medical research and public discourse, purposefully separating alcohol dependence from other, more stigmatised forms of addiction; alcohol was considered safe, it was the individual alcoholic who was the problem (Levine, 1978). Soon women also began to be reintroduced into

mainstream cultures of public drinking and by the 1960s alcohol started to be associated with sports, recreation and dining out.

In the face of a complete ban on many of drugs previously used as intoxicants, alcohol seemed to form a new state sanctioned outlet for inebriation (Fitzgerald & Jordan, 2011). This made way for the further stigmatisation and marginalisation of those now firmly deemed 'illicit drug users' and 'drug addicts'. Due in part to the increased regulation of drugs, a deep division between legal medical use and illegal non-medical 'abuse' began to emerge in the social milieu of Australian culture. Drugs that occupied the wrong side of this divide were now commonly, though often misleadingly, referred to as 'narcotics'. These newly termed narcotics and those who consumed them were considered to embody the antithesis of good sense and social responsibility. By the 1960s 'drugs' simply did not signify a single, unified cultural meaning anymore. Heroin was no longer just a 'drug', but a narcotic as well; alcohol was no longer a drug at all, rather it was a drink; cigarettes became smokes; morphine became medicine.

The Pharmaceutical Benefits Scheme

The introduction of the Pharmaceutical Benefits Scheme (PBS) in 1948 is another key example of the way medical and government regulation had become intimately intertwined. As Australia moved into the second half of the twentieth century its political and bureaucratic systems of drug regulation relied increasingly on the medical profession.

During his Prime Ministership (1945-1949) Ben Chifley embarked on an ambitious campaign to create a British-style National Health Service for Australia. As part of this campaign in 1948 Chifley introduced the PBS. In its early incarnations the PBS was a limited scheme which provided 139 “life-saving and disease preventing” drugs free of charge to pensioners and others in the community (Commonwealth of Australia, 2013). Most of Chifley’s health reforms were eventually ruled unconstitutional by the High Court of Australia, with the exception of the PBS. Established in 1953 the Pharmaceutical Benefits Advisory Committee (PBAC) decided what pharmaceuticals would be included in the government’s Formulary, and thus what was available under the PBS. The PBAC eventually became an independent statutory body under the *National Health Act 1953*, mostly comprised of members of the medical profession.

By 1960 the PBS had been expanded and nominal user charges began to be applied. The benefits of more affordable medications were politically resonant and continued to gain popularity. The 1970s saw large-scale increases in the products available on the PBS, and the government expenditure that accompanied it (Biggs, 2002). As expenditure grew so did the nominal charges that were applied to the medications. Still, it was not until the mid-1980s that patient contributions were significantly increased to off-set the major expenditure that the PBS now represented. Since its implementation each government had expanded the PBS program, further entrenching the cultural distinctions between legal and illegal drugs. Perhaps more importantly though, the PBS formed part of a wider process of normalising the consumption of pharmaceuticals in medical treatment

(Crawford, 1980) and the medicalisation of Australian society fuelled the expansion of the PBS.

The trend of medicalisation and increases in pharmaceutical intervention were also occurring in other developed nations with established traditions of 'Western medicine'. Observations about medicalisation and the growth of 'pill-culture' were prominent in North America and the UK (Hogshire & Alfvegren, 1999; B. Jackson, 1966; Miles, 1953). The consumption of pills was becoming a common part of everyday life for most developed nations. For Australians this global trend was being legitimised by expansions to the PBS.

By the time nominal charges to the PBS had increased significantly in the 1980s pharmaceuticals had been a staple of the developed world for decades, and their subsidisation in Australia for nearly as long meant that their use had become deeply. The expansion of the PBS during the second half of the twentieth century reinforced medical authority and the growing perception of 'safety' attached to the medications available on its formulary. The similarities with the state-sanctioning of alcohol – discussed in the previous section – are salient. The removal of barriers to alcohol consumption and the introduction of the subsidisation of pharmaceuticals seemed to permissively condone the consumption of these drugs, at least as compared to illicit drugs.

'A cup of tea, a Bex, and a good lie down'

The consumption of OTC headache powders forms an important part of a legacy of the normalisation of pharmaceuticals and the medicalisation of pain in Australian history. Prior to the introduction of the PBS, analgesic powder medications had been very popular in Australia. As far back as 1907 one observer points out “What the drink habit is to men in Australia, the headache powder is among women” (Murray, 1980: 9). Products such as Bex and Vincent’s powders were OTC analgesics recommended for the treatment of minor aches and pains. Bex and Vincent’s powders contained, as their main ingredients, a combination of aspirin, phenacetin and caffeine (APC), and were used as a cure for low moods, a remedy to help calm you down, and a painkiller. During the 1950s Australia became the largest consumer of OTC analgesics in the world, particularly APCs (Shelley, 1967).

Due to the high levels of APC consumption during the 1950s there was a sharp increase in chronic gastric ulceration (Billington, 1960; Billington, 1963) and kidney failure (Kincain-Smith, 1969) in women in particular – the condition became known as analgesic nephropathy (Stelle, Gyory, & Edwards, 1969). However, the medical community in Australia resisted the notion that legally available medications like Bex and Vincent’s could be implicated in the increase of gastrointestinal complications and kidney failure (Murray, 1980). The divide between legal and illegal drugs, which the medical profession was instrumental in establishing, implied that those who were legally obtaining their drugs should not be condemned. The illegal drug users, it was thought, were the ‘real’ problem (Manderson, 1993). Reluctance to acknowledge the connection between increased consumption of APCs and medical complications was clearly tied to the now entrenched

cultural assumption that legal medications were 'safe' and illegal drugs were 'dangerous'.

During the middle of the twentieth century many Australians used APCs regularly (Stewart, 1978), some daily, and trepidation to confront the complications associated with APC consumption was linked to a reluctance to undermine the safe/dangerous drug dynamic. In a 1980 publication in the *British Journal of Addiction*, Murray observes that:

Not only was there reluctance to admit that everyday medicines like aspirin and phenacetin could cause kidney damage, but there was also resistance to the idea that the drugs were being taken for other than medical reasons. (Murray, 1980: 10)

Furthermore, it has also been argued that APCs were a mechanism for the continued domestic control of women who felt unhappy in the 1950s

As a cure-all for women who felt unwell or depressed, 'a Bex and a good lie down' was an Australian cultural tradition. It was a way to suppress women's feelings of alienation, an agency of their oppression, and an easy means of social control. (Manderson, 1993: 136)

With the combination of a threat to social order and the promise of the continued domestic control of women, the status quo surrounding the safety of OTC medications – APCs in particular – was firmly cemented in Australian culture throughout the 1950s.

It was not until the 1960s that the medical profession formally acknowledged the link between analgesic nephropathy and the use of APCs. Subsequently the early 1960s saw a slight decrease in the importation of phenacetin into Australia (Hennessey, 1993). However, medical evidence linking APC consumption and gastrointestinal and kidney complications was still limited. In an attempt to explain away the issue, excessive APC consumption became presented as a 'female problem'. Largely as a result of the growing influence of psychology, an increasing number of undesirable and socially unacceptable behaviours exhibited by women were being diagnosed (or rather misdiagnosed) as symptoms of 'hysteria' (Hennessey, 1992). In an article published in the *Annals of Internal Medicine* in 1968, the authors describe the 'typical' analgesic nephropathy patient as a female whose:

life history reveals a broken home, an early short-lived marriage, and frequent loss of time from work due to illness. She suffers from insomnia, takes sedatives, and a few years ago took an overdose. She complains, tearfully of weakness, indigestion, and recent vomiting. Most oppressive are her headaches which she has had for twenty years, but which have become virtually continuous and are driving her to thoughts of suicide. Her medical history is lengthy and includes neurological, haematological, psychiatric, and gastro-intestinal evaluations. She was hospitalised for depression and five years ago had a gastrectomy for a bleeding peptic ulcer. (Gault et al., 1968: 14)

The representation of APC consumption as a 'female problem' invisibilised the wider circumstances which drove women to take APCs and the specific pharmacological imperatives that kept women dependent on the drug.

In Australia the 1950s were a time of contradiction for many women, where changing dynamics, domestic responsibilities, and marital commitments were in constant conflict. Women were forced back into domesticity after the male population returned from the Second World War. While some women seemed to welcome the change, many others felt the boredom of domestic living was unbearable in comparison to the excitement of the working world (Hartman, 1978). The increase in child birth during the 'baby boom' era meant women's domestic responsibility grew with the amount of children they had (Burnley, 1982). Speedy advances in technology were thought to make housework quicker and less demanding, however the standard of cleanliness was now raised substantially, and a greater focus was placed on women to remain youthful and physically attractive (Hennessey, 1992).

By the 1960s the amount of married women in the work force had grown substantially, yet women's work was still mostly considered unimportant. Hennessey writes that:

despite growing community recognition that many women were finding it increasingly difficult to cope with the demands placed on them, the cause of their stress and tension was not perceived as overwork. Rather it was diagnosed as personal inadequacy, more a

function of being a woman than a product of women's work. (1992: 260)

The circumstances of women's lives were left out of the equation in medical accounts about APC consumption.

The medical community focussed its resources on isolating the nephrotoxic properties of APCs, while ignoring their energy boosting components and the potential for people to become dependent on them. Professor Priscilla Kincaid's work on analgesic nephropathy was influential in eventually discovering that the combination of aspirin and phenacetin was most damaging (Australian Academy of Science, 2003). However, it was not until the late 1960s that Kincaid's discoveries became well known among the medical community, and not until the late 1970s that legislation was introduced to control the combination of aspirin and phenacetin in OTC analgesics.

The effects of caffeine on those consuming APCs were largely ignored until the 1970s. As a major component of APCs, caffeine is a central nervous system stimulant that released the energy that women of the time needed to meet the growing demands placed on them. The regular consumption of caffeine creates a steadily increasing tolerance, which meant that women were taking more and more Bex and Vincent's powders to get the same burst of energy. Both the excessive consumption of and withdrawal from caffeine induces the kind of headaches that so many women of the time complained of. Knowledge of caffeine headaches was available to the medical community in Australia since at least the 1940s (Dreisbach &

Pfeiffer, 1943), and yet at the time women's headaches were still mostly dismissed as symptoms of hysteria. This meant that women were steadily increasing their dose of APCs to get the same energy boosting effects, while at the same time the amount of caffeine intake was inducing headaches, which were dismissed as symptoms of neurosis. Due to caffeine withdrawal, any attempt to stop using APCs only made the headaches worse. In amongst this vicious cycle, women were first told that the drugs they were consuming were entirely safe, then safe in moderation, then, once a nation of women were thoroughly dependent, that their compulsive consumption was a symptom of psychiatric dysfunction and personal inadequacy.

This controversy is an important instance of the medicalisation of pain in Australian society. The desire to medicate physical pain alongside emotional difficulty is also an important part of the controversy. Another key element of the controversy is the historical conditions that established a perceived 'safety' around pharmaceuticals. It is this impression of safety that informed the medical profession's reluctance to acknowledge and slow response to the harmful effects of APCs, as well as the ease with which most women took to the use of such medications. The remainder of this chapter addresses the other component of the safe/dangerous drug dynamic: drugs thought to be 'harmful' and 'dangerous'. It deals with trends in Western approaches to social welfare, as well as the emergence of 'war on drugs' rhetoric and harm minimisation policy.

Neoliberalism and the 'War on Drugs'

The harms associated with illicit drug use are often presented as being caused by the properties of the drug or the choices of its consumer, while the political economy that informs problematic drug use is often relegated to the background. The history of opiate regulation, alcohol consumption and pharmaceutical and analgesic use outlined in the sections above illustrate the limitations of assuming pharmacology and psychology determine the harms of drugs use. A growing chorus of sociological, anthropological and public health research (Bourgois, 2002) has demonstrated that a focus on the pharmacology of the drug and the psychology of the consumer overdetermines their role in the take up of 'risky' or 'harmful' drug taking practices (Zinberg, 1986). Economic and social welfare policies are in fact central to the potential harms of drug use. This section elaborates on how the formation of political approaches to welfare and social support has changed in advanced liberal economies over the last century, and the links this has to the establishment of the 'War on Drugs'.

In the context of the US Great Depression during the early 1930s a series of monetary policies between 1933-1936, dubbed 'the new deal', provided financial support for and government intervention into struggling industries so that levels of employment could be stabilised. The importance of reducing unemployment came to inform a wider philosophy about the role of the state in economic management. A political philosophy about the role of the economy in ensuring the welfare of all citizens was subsequently

developed. Termed 'embedded liberalism' this approach has been briefly summarised as requiring that:

the state should focus on full employment, economic growth, and the welfare of its citizens, and that state power should be freely deployed, alongside of or, if necessary, intervening in or even substituting for market processes to achieve these ends. (Harvey, 2005: 10)

Embedded liberalism was both a political and economic philosophy that placed social welfare above the accumulation of individual wealth. The proliferation of embedded liberalism throughout global economic policy, especially during the middle of the twentieth century, produced high rates of economic growth in modern capitalist economies.

However, by the late-1960s and '70s the effectiveness of embedded liberalism began to collapse. Capitalist economies started showing signs of overaccumulation, and a related devaluing of capital investment. During the 1970s the world entered a phase of stubbornly stagnated inflation (or 'stagflation') that set the scene for a deliberate project by the wealthiest elements of the developed world to begin to introduce, what has come to be known as neoliberal economic policy (Harvey, 2005). Pursued by influential corporate and conservative interests, neoliberalism began as a political philosophy about the liberation of individual entrepreneurialism through frameworks of deregulated (or free) markets and trade. Though it emerged in uneven ways across the globe, its influence in economic policy has become widespread.

Harvey (2005) has noted that a series of key political and policy events during the late-1970s and early 1980s mark the start of 'the neoliberal turn'. Since then the 'free market' mentality has formed part of a larger philosophy about limiting the role of government in order to unleash the entrepreneurial potential of the individual. This dovetailed with the popularisation of evolutionary science and the belief that 'survival of the fittest' prevailed in the market as well as the jungle. The spread of neoliberal thought has contributed to the remaking of the modern condition in disparate areas such as "divisions of labour, social relations, welfare provisions, technological mixes, ways of life and thought, reproductive activities, attachments to the land and habits of the heart" (Harvey, 2005: 2). However, the liberalisation of drug regulation was exempt from the neoliberal interest in individual freedom, largely because neoliberalism was associated with conservative elements within the political system that had traditionally championed drug prohibition.

As the 'Western world' moved into the second half of the twentieth century unequal access to the ideals of modern consumerism (Young, 2011), coupled with reduced investment in social support (Reiner, 2012) exacerbated the criminalising imperative of much drug legislation in advanced liberal economies. Class interests seeking a reduction in government intervention into the accumulation of individual wealth seized upon the international trend of stagflation during the 1960s and 70s as an opportunity to erode popular consensus about the social welfare and social democratic role of the state.

This period saw unprecedented increases in drug use and associated drug convictions (Gahlinger, 2004). Strong links have since been developed between neoliberal policies and the development of problem drug use (Punch, 2005; Room, 2005; Singer, 2008). Increased levels of income inequality are an identifiable consequences of neoliberal economic management (Baer & Maloney, 1997; Navarro, 2007), which has contributed to a range of adverse health outcomes, with harmful drug use high among the list (De Vogli, 2011; Galea, Ahern, & Vlahov, 2003; Wilkinson, Marmot, & Europe, 2003). America's 'war on drugs' played into aspects of the erosion of traditional liberal approaches to welfare and social support.

In 1968 Richard Nixon won the US Presidency on the promise that he would 'restore law and order', drawing in particular on the issue of drug control. In 1972 President Nixon declared a 'total war against dangerous drugs', launching the term 'war on drugs' into the popular vernacular. Domestically, Nixon's 'war on drugs' was simply a continuation of already well-established prohibitionist policy. However as a result of a sharper focus on the issue, partly through the creation of the new Drug Enforcement Agency (DEA), an increase in drug related convictions meant the prison system began to fill at unprecedented rates (Gahlinger, 2004).

Nixon's 'war on drugs' had implications for the international community, particularly as he had begun to emphasise that the supply of 'dangerous substances' were from international sources. Nixon represented the 'drug problem' as a foreign threat to the American (and 'Western') way of life. Supply reduction, enforced through the threat of international embargoes and other forms of often militarised hostility, became the

centrepiece of international drug policy. Australian drug policy never formally adopted a 'war on drugs', but it did incorporate significant aspects of US drug policy and law enforcement at the time.

The introduction of an American 'war on drugs', and its implications around the world, had a transformative impact on the political climate of the 1970s. In response to the defiance of countercultural drug cultures, concern about the physical dangers of illegal drugs gave way to concern over their 'social impact'. References to narcotics were being replaced with discussion about the 'misuse' and 'abuse' of drugs. Race observes that concern about drug use during the 1970s and '80s were "no longer [about] the scientific properties of specific substances, nor the physical dangers arising from their consumption" (2005). Instead concern began to surround "the character of their use [and] its deviation from [the] professional authority, that form[ed] the locus of juridical consideration" (Race, 2005).

Medical authority once again emerged as important in defining the acceptable use of a drug, and thus also what constituted its 'misuse'. A move towards a language of 'misuse' and 'abuse' cemented the impression of social deviance that had been engendered by the medical profession throughout the century. However in contrast to previous bans on opium smoking, the 'war on drugs' did not focus on 'proper' or 'improper' forms of consumption, but rather on the legal status of a drug itself. Any consumption of an illicit drug was considered non-medical, and thus constituted 'misuse' and/or 'abuse' (Manderson, 1995; Race, 2005).

Australia continued to follow trends in drug enforcement throughout the 1970s with the ratification of a range of international treaties relating to

drugs, including the *Convention on Psychotropic Substances 1971* and the *Protocol Amending the Single Convention 1972*. These conventions provided limited recognition of the disappointing progress of the international model of prohibition, calling for more attention to health and social outcomes (Miller, 2009). Despite this the international community remained committed to the supply and demand reduction approaches that had been reinvigorated by a devolving of the importance of the social welfare function of the state.

During the 1970s the Commonwealth implemented the *Customs Amendment Act No. 2 1971 (Cwlth)*, which made the traffic of a 'drug of addiction' a separate offence. Following this Commonwealth legislation, the *Poisons (Amendment) Act 1970 (NSW)* brought NSW up to speed with its state counterparts by making it a separate offence to sell or deal a 'drug of addiction' (Manderson, 1993). Where it was once a criminal offence to be in possession of an illegally imported substance, it now became an offence to possess any narcotic 'reasonably suspected' of being illegally imported. Australian drug policy during this time was dominated by a range of adjustments to existing legislation that modified the definition of drug offences to make their conviction easier and their punishment harsher (Manderson, 1993).

Adjustments to the legislation of drug offences also predictably translated into significant increases in the concentration of policing and law enforcement. During the 1970s the Australian Bureau of Statistics recorded spikes in rates of drug offences in all jurisdictions around the country. In 1974-75 NSW recorded 83.6 (per 100,000 population) drug offences, with

Queensland recording 87.5 and 53.1 in Victoria: by 1977-78 those rates had raised to 204.4 (NSW), 135.7 (Qld) and 99.7 (Vic) respectively (Wardlaw & Deane, 1986). The authors of an AIC report noted that these data are largely a “measure of police activity”, and is thus limited in its ability to quantify apparent increases in drug use itself (Wardlaw & Deane, 1986: 2). It is also worth noting that within the larger jurisdictions, such as NSW and Qld, offences related to the selling or supply of drugs consistently remained lower than 10 per cent of all recorded drug offences. This reveals a formulaic targeting of user-level populations for drug law enforcement that mimicked the approach of the DEA.

It is useful to reflect on what this kind of policing reveals about the governance of Australian citizens at the time and its resonance with contemporary forms of drug related law enforcement. The targeting of street level drug use assumes that people who use drugs have the capacity to ‘choose otherwise’ and thus the threat of criminal charges is presented as a method to deter illicit consumption (Aitken, et al., 2002; Cooper et al., 2005). Systems of law enforcement that target people who use drugs as a form of deterrence reduce choices about ‘risky behaviour’ to a simple matter of rational calculation: comparisons to neoliberal emphasis on the responsabilisation of health practice (Petersen & Lupton, 1996) are salient. This model tends to obscure social structures that produce the kind of marginalisation present in the communities in which dependent drug use is most common (Meares, 1997). The police targeting of individual drug consumers has also been critiqued for amplifying the ‘risk environment’ in which drug use occurs (Moore, 2004). Despite its limitations and

shortcomings, the policing of street-level drug use remains an important part of contemporary law enforcement, particularly as it relates to injecting drug use (IDU) (Aitken et al., 2002).

In Australia the shadow of an international ‘war on drugs’ translated into accounts of a ‘social problem’ characterised by the ‘deviance’ of people who use drugs. Rather than directing the majority of policing resources to the health needs of people who use drugs, or to interrupt the manufacture and sale of drugs, the 1970s saw notable increases in police targeting of individual drug users. While the criminalising imperative of this approach had popular support, sections of the community welfare and public health sectors began to emphasise the need to focus on better health and social outcomes.

Harm minimisation

Harm minimisation policy and advocacy emerged out of a series of overlapping interest in politics, medicine and public health. In Australia, it was made possible because of the tragic circumstances that surrounded the daughter of a sitting Prime Minister. At a press conference in 1984 Bob Hawke revealed that his daughter was a “heroin addict”. The announcement introduced unprecedented interest in and activity around Australian drug policy (McArthur, 1999b). In April of the next year the Prime Minister and the Premiers and Chief Ministers of all seven States and Territories gathered for a meeting in the nation’s capital, Canberra. The meeting resulted in the

creation of a new policy program to address drug use in Australia called the National Campaign Against Drug Abuse. The name of the policy was eventually changed to the less dramatic National Drug Strategy (NDS), but its fundamentals as a three pronged approach to reduce the supply, demand and harm of drugs has remained unchanged (Lewis & MacPherson, 2007). The significance of the new policy rested in its adoption of, what has been termed a harm reduction component.

Given the context in which this new initiative was formed, harm minimisation is often held up as a 'balanced approach' developed with "strong bipartisan political support" (Australian Government, 2013). The problem with the development of harm minimisation was that the policy had, and perhaps still has no clear definition. The new policy introduced in 1985 gave no definition for the harm reduction component and it subsequently became exposed to the competing and conflicted agendas that comprise drug regulation: "'harm minimisation' is that most unfortunate of beings—a term in search of a meaning" (Wodak & Saunders, 1995). For years preceding its introduction 'harm minimisation' had been broadly applied to any policy measures that claimed to 'reduce harm' associated with drug use. This included prohibitionist and policing strategy, as well as public health and treatment programs. A clearer impression of the policy agenda can be located in the kinds of programs that have since become closely associated with a framework of harm minimisation.

Joining a growing chorus of concern over the HIV/AIDs epidemic gripping many parts of the world, harm minimisation proponents found a defining victory in the establishment of needle and syringe programs (NSP)

in the late 1980s (Inciardi & Harrison, 1999). NSP are programs that provide sterile injecting equipment to people who inject drugs (PWID) so that they are encouraged not to share needles that carry blood borne viruses. The spread of HIV in the 1980s was associated with the gay and IDU population of industrial nations (Blattner, 1991). The introduction of NSP was born out of anxiety about the spread of HIV to other parts of the community. Its origins outside Australia are most closely tied to the neoliberal health policies of the conservative Thatcher government in the UK (O'Hare, 2007).

Since the 1980s sections of public health have taken up a neoliberal philosophy that places emphasis on individual responsibility for health. Petersen and Lupton have described this trend as part of the emergence of what has been termed 'the new public health', which is "at its core a moral enterprise" (1996: 174). As classic modernist institutions, medicine and epidemiology rely on the production of 'expert knowledge' about health and the ways of life that maximize health outcomes. Neoliberal health policy assumes that people have equal access to health knowledge, unmitigated by circumstance or sociality, and that people therefore have the capacity to make 'healthy life choices'. As noted above, a similar philosophy informs policing practices that target street-based IDU. As part of a philosophy about this kind of responsabilisation of healthcare, Thatcher adopted a programme of needle and syringe exchanges in the UK in 1986. With the support of medical and public health practitioners Australia's first NSP was established in the same year, with a national network of programs implemented over the next few years (Wodak & Cooney, 2005).

The precedent set by the introduction of NSP galvanized advocacy efforts around an alternative to prohibitionist policies. This provided many harm minimisation advocates with a defining purpose that was distinct from the responsabilisation of health endorsed by Thatcher. Harm minimisation advocates emerged with a clear goal, to “prevent the baleful consequences of drug use without setting out to achieve this objective by interfering with drug consumption” (Wodak & Saunders, 1995: 269). Proponents of prohibition constantly accuse this kind of harm minimisation agenda of ‘sending the wrong message’, and implicitly endorsing illicit consumption. This is illustrative of an important philosophical distinction between prohibitionist policies that seek to address imagined future harms to society and harm minimisation initiatives that address immediate harm to people who use drugs. There are however other policies that are presented under a harm minimisation framework that demonstrate a blurrier model of reducing harm.

Since the 1980s the use of opioid substitution treatment (OST) has also been largely framed as a harm minimisation initiative. OST provides a stable prescription of a pharmaceutical opioid (PO) to medically maintain people who are dependent on opiates. The continued consumption and indeed prescription of a psychoactive drug is important in its subsequent integration into harm minimisation frameworks. American researchers Dole and Nyswander are largely credited with establishing the medical viability of OST in a study using methadone. Dole and Nyswander reported marked shifts in the behaviour of patients who received daily doses of methadone, and argued that medically maintaining drug dependent people, even if it was

for the rest of their lives, would serve to reduce morbidity, mortality, crime, and other associated social problems (Dole & Nyswander, 1967).

Methadone was introduced to Australia in the experimental capacity of an opioid substitution drug in the early 1970's, and has been used with varying popularity and success ever since (McArthur, 1999a). High-dose formulations of buprenorphine for the treatment of dependence became available in Australia in the mid-2000s (Jenkinson et al., 2005). Buprenorphine-naloxone was introduced to Australia in 2006, largely in response to concerns that buprenorphine – and to a lesser extent methadone – was being injected (Larance et al., 2011).

Despite being presented under the humanitarian framework of harm minimisation, critiques of the administration of OST have pointed to the constraints they place on clients. The status of OST as harm minimisation is complicated by the fact that most prescribers and dispensers specify abstinence from heroin or other opioid injecting, among an array of other behavioural requirements, in order to stay on the program. Authors such as Bourgois (2000), Friedman and Alicea (2001), and Harris and McElrath (2012) even accuse US methadone programs of operating as a form of medical surveillance that chemically leashes clients, limiting their ability to fully participate in society. Australian researchers Fraser and valentine provide a more nuanced account of methadone programs in Victoria and New South Wales by describing how they both reproduce and interrupt typical accounts of 'drug addiction' (Fraser & valentine, 2008).

While harm minimisation was being defined throughout the 1980s, drug policy presented a highly conflicted account of prohibitionist (supply

and demand reduction) and public health (harm reduction) philosophies. As a result prohibitionist discourse itself began to adapt to compensate for the humanitarian concerns raised by those advocating harm minimisation, though not necessarily to the benefit of people who used drugs. Throughout the 1980s prohibition advocates in Australia began to frame their policy agenda as in defence of people “falling victim” to the criminal activities of “drug pushers” (Manderson, 1993). Law enforcement also adjusted its rhetoric to focus on the traffic and sale of drugs. A new political discourse soon emerged that made an explicit distinction between ‘users’ and ‘dealers’.

The user/dealer distinction became a political tool, lending the national policy of drug enforcement the appearance that it was operating in the interest of people who used drugs. Yet the practicalities of policing illicit drug markets left the common ‘drug user’ arguably even more exposed to law enforcement and the criminal justice system (Maher & Dixon, 2001; Rowe, 2005). The dichotomisation of ‘users’ and ‘dealers’ ignores their obvious interconnectedness. Many people who use drugs regularly often also sell them to support their dependence (Maher, 2000). In the policing of drugs the two worlds thus become inseparable, because people who use drugs have obvious insight into the activities of those who sell them, and are much easier to identify than ‘dealers’ and ‘traffickers’. This led to a reinvigorated pursuit of people who use drugs, who were often intimidated into cooperation with the threat of criminal charges, and rarely presented with therapeutic options (Chambliss, 1995).

As Australia moved into the 1990s and 2000s, tensions between advocacy efforts that centred on harm minimisation and policy agendas that emphasised prohibition were becoming increasingly pronounced. Though the official harm reduction policy continued, and its support from specialist medical and public health domains remained, little was being done to implement a harm minimisation agenda. In an effort to combat HIV transmission and related harms through less punitive measures, a range of user organisations were established. The Australian Injecting and Illicit Drug Users League (AIVL) began community health work in the late 1980s, and became a fully incorporated association in 1992. Similar activist and community organisations were also formed at the state level, most notably with the NSW Users and AIDS Association (NUUA) in 1989. Leading into the twenty-first century AIVL, NUUA and similar organisations began to establish momentum for advocacy of harm minimisation.

However in November 1997, at the leadership of then Prime Minister John Howard, the new conservative government announced its drug strategy, openly introducing drug war rhetoric onto the national stage (Mendes, 2007). Prime Minister Howard himself vetoed a bill that would have initiated a heroin trial in the ACT “despite years of multidisciplinary feasibility studies and the approval of a majority of the state, territory and federal police and health ministers” (Mendes, 2007: 5). In light of rhetorical opposition at the Federal level, harm minimisation became symbolic of an alternative to the prohibitionist policies that were failing many communities across Australia.

The late 1990s saw reports of a 'heroin drought' in Australia dominate media coverage of drug use (Poynting & Morgan, 2007). A significant spike in heroin overdose deaths in the inner-city region of Sydney quickly followed. On January 31, 1999, *The Sun-Herald* published a photo of what appeared to be a 15-year-old being injecting with heroin by a staff member at an NSP in Corline Lane, Redfern. On the cusp a state election, the image and accompanying article sparked a political row over the effectiveness of the state's NSPs. Bob Carr's Labor government won re-election having promised the initiation of a Drug Summit, which eventually recommended, among other things, the establishment of a supervised injecting site. Despite some public opposition Sydney's Medically Supervised Injecting Centre (MSIC), the first of its kind in the world, opened on a trial basis in May of 2001 (Freeman et al., 2005).

MSIC has become firmly identified as a harm minimisation measure that seeks to reduce the harms associated with drugs without necessarily reducing drug use itself. Evaluations of the facility in 2003 and 2007 both provided compelling evidence that the MSIC was affordably achieving its goal to reduce many of the harms associated with drug use. The NSW government extended the trial basis of the facility following each successful evaluation (van Beek et al., 2004). After operating for nearly 10 years on a trial basis, the NSW government legislated the facility as a permanent fixture in 2010.

Between medical and self-regulation

The histories discussed in this chapter reveal important societal changes that were variously responsible for and the consequence of shifting approaches to drugs. The medical profession has played a leading role in the regulation of analgesic and opiate consumption over the last century. Importantly, medicine has defined the socially constructed distinctions between the legal and therapeutic status of drugs. This has however contributed to the development of naïve discourse about ‘good’ and ‘bad’ drugs, ‘benign’ and ‘addictive’ consumption, and at times disguised the harms associated with legal medications and exaggerated the harms of illicit drugs (Manderson, 1993). Medical discourse has also been used to legitimise increasingly punitive drug policy and policing practice, which in many cases produces harms of its own (Levine, 2003). The historical influence of medicine is tied to political and professional interests that are often presented under the guise of scientific consensus.

The encroachment of consumer and neoliberal discourses informs a degree of contestation to medical and legal authorities in the field of drug regulation. The commercial and class interests that propelled neoliberal policies about the entrepreneurial capacity of the individual in the ‘free market’ form part of a trend towards self-regulation. Public health has at times borrowed from the neoliberal philosophy of individual responsibility for health (Petersen & Lupton, 1996), most notably with the introduction of NSP in the UK and Australia (Zibbell, 2004). Though harm minimisation is more closely associated with activist movements and community

organisations, its policies often involve a call to allow the individual the responsibility to regulate the consumption of drugs.

These frameworks of medical and self-regulation of drugs in Australia have also been intimately tied to moral judgments about the people who are consuming them and the lives they lead. Opposition to Chinese migration and opium smoking emerged alongside objections to the apparent threat posed by the presence and 'sexual perversity' of the Chinaman in Australia in the early twentieth century. The historical influence of addiction in medical research has also produced moralised distinctions between different paths to drug dependence and the way they are policed in the shadow of a 'war on drugs'. These moral positions are juxtaposed with the unthreatening use of pharmaceuticals and alcohol, whose characterisation as 'safe' was propelled by the implementation of the PBS and liberalisation of alcohol legislation during the middle part of the twentieth century.

By taking a historical perspective this chapter has revealed how transformations in Australian approaches to drug regulation have little to do with the scientific 'discovery' of the harmful properties of illicit drugs. Rather, forms of medical and self-regulation appear to intersect with the legal and moral histories that make up the political economy of drug consumption. These regulatory frameworks remain contested and fluid, presenting a series of tensions between medical authority, political influence, social change, commercial interests and neoliberal discourse. As a result painkillers and analgesics emerge as intermediary objects that slip between the categories of legal and illegal, medical and non-medical, and moral and immoral, depending on the context of consumption.

Conclusion

This chapter has discussed the overlap between the social and legal regulation of drugs in Australia over the last century. In particular, it foregrounded how political and expert knowledge has shaped the distinction between licit and illicit drugs. It also outlined how the strict legal controls of substances deemed illicit have come under challenge from consumer and neoliberal cultures that promote self-autonomy and self-responsibility in medical consumption. This focus on individual choice and agency overlaps in important ways with discourses of health promotion and public health.

The histories of drug use discussed in the chapter provide a critical framework for understanding the way drug use is framed, both in research and as an issue of public policy. The next chapter will critically interrogate the way contemporary research about non-medical consumption tends to ignore the implications of discourse and the social construction of the painkiller. It explores how knowledge about non-medical consumption is produced in models of clinical research, which often overlook the political economies in which research is conducted and drug use occurs.

Chapter Three – Meaning and measurement of non-medical consumption

A growing body of research literature has adopted a discourse of ‘abuse’ to describe the non-medical consumption of pharmaceutical painkillers. In a manner comparable with their role in distinguishing between ‘licit’ and ‘illicit’ opiates, the medical profession is extending a discourse of ‘abuse’ to include the consumption of analgesic medications in unauthorised ways. Where the previous chapter identified the socio-historical context under which pain medications became the antithesis of ‘street drugs’, this chapter outlines changes in medical discourse about pain medications and their capacity to be ‘misused’. The medical literature now commonly presents non-medical painkiller ‘abuse’ as a scientific ‘discovery’ about an apparently new and emerging drug problem. A large body of epidemiological literature has also contributed to the proliferation of a language of abuse to describe non-medical consumption. Epidemiologists write about a range of ‘factors’ that ‘contribute’ to the perceived prevalence of painkiller ‘abuse’ and ‘misuse’.

This chapter performs two central tasks through a critical review of the available literature. First it examines the conceptual frameworks of a growing body of US literature before moving to address the way these inform Australian research and commentary about non-medical (ab)use. The chapter begins with a critical evaluation of the influential definition of the (US) Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services. It then discusses the

terminology used in the dissemination of epidemiological research, and addresses the way psychological literature produces practices of non-medical consumption within pathologising frameworks.

Much North American research is underpinned by an emphasis on medical authority and a tendency towards pathologisation, which in turn informs the Australian research and policy responses to the non-medical use of painkillers. The remainder of the chapter thus focuses specifically on the Australian context. Assessment of Australian literature starts with a review of national data collection and its limitations. Smaller studies, and institutional and government responses are also considered. This chapter provides a critical assessment of the kind of knowledge being produced about non-medical use through such research.

Defining the practice

Most research into non-medical consumption uses the definition of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services. As advised by the SAMHSA “non-medical use” is usually thought to refer to “the use of a prescription drug when ‘it was not prescribed for you’, or that was taken ‘only for the experience or feeling it cause[s]’” (Sees et al., 2005). This definition articulates two broad categories of ‘concern’ about medication consumption, based on (a) prescription as the only legitimate method of acquisition and (b) medically defined benefit as the only legitimate motive

for consumption. These ‘concerns’ are integrated throughout the research literature and are often used to infer dysfunction and criminality. This section will provide a brief critique of the SAMHSA definition before elaborating on the impacts of these definitional problems on the field of substance abuse prevention and treatment.

Beginning with the first concern, it is significant to note that the SAMHSA definition relates directly to prescription medications and makes no reference to OTC medications. This is despite the fact that discourses of pharmaceutical (ab)use include apparent overuse of OTC medications with sometimes serious health implications. However the SAMHSA definition binds ‘legitimate medical use’ to ‘ownership’ of a specific prescription. The therapeutic action of a particular medical treatment is therefore irrelevant to this definition of abuse. Under the SAMHSA definition, use of the same medicine, for the same medical purpose may well be rendered non-medical if it is acquired through a prescription addressed to a friend or family member. Here the actual effect of consumption becomes irrelevant to the definition, which is focused on the possible wilful deceit of medical practitioners by clients or the use of prescriptions for purposes other than those intended by the practitioner.

A 2005 study utilising the SAMHSA definition acknowledges how the limitations of the first criterion may produce a problematic reading of survey results:

[a] positive answer to the specific survey question could mean that the respondent had... taken one dose of a specific pain reliever to treat

pain, although the medication was not prescribed for that particular pain problem. While such use is clearly 'non-medical', it does not meet established criteria for 'abuse'. (Sees et al., 2005: 22)

The first criterion of the SAMHSA definition implies that 'legitimate' consumption is bound to an interaction within the medical clinic, between prescriber and patient. This kind of approach discounts any consideration of what might be happening in the life of the consumer outside the medical clinic. What if a patient's pain suddenly flares up when they are not in the presence of a doctor? Should they refuse a dose of their friend's pain medication simply because it was not prescribed to them? These kinds of considerations are left out of the SAMHSA definition and, as we shall see in the rest of the chapter, can become problematically implicated in discourses of dysfunction and crime.

The second dimension of the SAMHSAs definition of non-medical consumption is focused on use for the sole purpose of the 'experience' or 'feeling' of the medication. This criterion is somewhat unique in terms of its influence in epidemiological research, which has long neglected the role of pleasure in drug use (Moore, 2008; Treloar & Holt, 2006). Despite this emphasis on 'experience' and 'feeling', the epidemiological literature still tends to deal with pleasure-seeking as a criterion for non-medical use, rather than as a motivation. Chronic pain research challenges this delegitimation of drug consumption for 'subjective' reasons such as experience or feeling. Concerns about the under treatment of pain (S.D. Passik & Kirsh, 2004), a worsening of the patient's condition (Littlejohn,

Baldacchino, & Bannister, 2004), or anxiety about the treatment of chronic pain (Kirsh et al., 2007) have all raised important questions about positioning the 'experience' or 'feeling' of painkiller use as problematic.

Chronic pain research has demonstrated that many patients actively seek the drug in question precisely for the experience or feeling that it causes (Kwon et al., 2014). Indeed the experience or feeling of the drug is what acts as therapeutic and allows for the patient to live unburdened by crippling chronic pain, depression or anxiety. The next chapter will elaborate on the significance of pain medicine, but for now it is enough to note that, for patients with persistent pain problems, enjoying the relief that their medications provide may be entirely expected. How the SAMHSA distinguishes between 'experience' of the drug as recreational and as therapeutic is also unclear. Moreover, there is little evidence that the recreational and therapeutic 'feeling' of drug consumption can in fact be separated so neatly.

A final observation about the SAMHSA definition is that it attempts to produce generic criteria for 'legitimate medical use' and 'illegitimate non-medical abuse'. As was noted in Chapter Two, a substance's status as medication is closely tied to medical narratives about its therapeutic value within a particular treatment program. All pharmaceuticals have their own patent regulations under professional guidelines, and recommendations for the medical use of analgesics will differ from those of other medications. Generic guidelines seem to relate much more to medical authority than to therapeutic practice. Tied up in the implicit agenda of reinforcing medical authority the SAMHSA definition thus presents a series of problems when

used as an indicator for problematic ‘abuse’. The next section explores the terminology used to articulate findings related to these definitions, and what they reveal about an emerging discourse of pharmaceutical ‘abuse’.

Terminology in the field

Following from the SAMHSA definition, terminology about non-medical use usually relates to either modes of acquisition or motives for consumption. In clinical discourse there are multiple terms used to describe practices of non-medical use. A significant background to the terminology used in the literature is the way medical and scientific accounts describe ‘abuse’ of drugs generally. Part of the reason why attention has come to the term ‘abuse’ is because medical and scientific communities have sought to differentiate between the medically appropriate use of opiates and the medically unauthorised ‘abuse’ of the same substances. In a series of influential articles published by Nora Volkow, the director National Institute on Drug Abuse (NIDA), it is argued that, when ‘substances of abuse’ are not used to address a medical condition, this can result in “decreased dopamine function in addicted subjects [which] results in decreased sensitivity to nondrug-related stimuli (including natural reinforcers) and disrupts frontal inhibition, both of which contribute to compulsive drug intake and impaired inhibitory control” (Volkow et al., 2004: 557). This argument is extended to a description of analgesic abuse specifically, and a case is made for the monitoring and surveillance of young people who consume opiates based on

the notion that their 'abuse' places them at risk of addiction (Compton & Volkow, 2006a, 2006b).

While use of the term 'abuse' provides an important backdrop to the way terms in the field are deployed, there are a wide range of terms used in the literature that need to be canvassed. Studies investigating the use of medications prescribed to someone other than the consumer refer to 'diversion' (Vivian et al., 2005), 'non-adherence' (Arria et al., 2011), 'misuse' (Kelly & Parsons, 2007) and 'abuse' (Catalano, 2009). Research investigating the apparent misuse of pharmaceuticals for the 'experience' or 'feeling' they cause include terms such as 'harmful use' (World Health Organisation, 2013), 'dependent use' (Davey et al., 1995) or 'aberrant medication-related behaviour' (Webster & Webster, 2005). Though each term is purposefully defined in each study, their use is often inconsistent and even interchangeable. This section discusses the terminology of non-medical use and the role of this vocabulary in establishing pharmaceutical 'abuse' as a coherent field of study.

Terminology related to the acquisition of pharmaceuticals deals specifically with how to categorise the way people who use medications non-medically gain access to them. The term 'doctor shopping' is used to describe the behaviour of patients who consult "several prescribers during the same period and obtaining overlapping prescription orders from these different prescribers" (Pradel et al., 2010: 612). A report from the Victorian Drugs and Crime Prevention Committee goes as far as exploring the "possibility of a criminal law for 'doctor shopping'" (2007: 16). Doctor shopping is often spoken about as a form of what is termed 'diversion'.

While some studies include non-medical consumption as part of the definition of diversion, most restrict use of the term to the supply of pharmaceuticals to 'illicit drug markets' (Ritter & Natale, 2005). According to a report from NDARC "diversion' describes the unsanctioned supply of regulated pharmaceuticals from legal sources to the illicit drug market, or to a user for whom the drugs were not intended" (Degenhardt et al., 2007: viii).

Attempts to measure the diversion of pharmaceuticals into illicit markets may however over-represent its role in practices of non-medical consumption because it conflates intention to on-sell drugs for profit with informal medication sharing. While respondents in studies of non-medical use consistently report family and friends as the most common source of access to medications, there is little discussion of practices of sharing. What references there are to acquiring medications from family and friends condemn them as 'illicit' or as a form of 'diversion' (Inciardi et al., 2009). The impact of people who take leftover medications or share them with family and friends on the resulting data is almost entirely ignored in the epidemiological literature.

A lack of attention to the social and cultural elements of networks of sharing reinforces discourses of 'abuse' and 'illegality'. Studies with a greater focus on the social and cultural aspects of drug use can provide some important insights here. In a qualitative study of methadone services in Victoria and New South Wales, Fraser and Valentine note how sharing medications can represent a practice of care (2008: 136). The authors observe that access to a steady supply of a medically prescribed opiate is precious, and that despite reducing their own supply and the risk of having

it cut off entirely, clients often share their methadone with intimate partners and friends who do not have access to a treatment program. As distinct from clinical guidelines which condemn the sharing of methadone, interpretations of interview data with service providers, policy makers and clients reveal, what the authors refer to as the “alternative treatment identity” of “the lay carer” (Fraser & Valentine, 2008: 136). The lay carer is one example of the kinds of alternative modes of understanding medication sharing that social and cultural approaches can bring to the study of non-medical use.

Terminology related to motives of consumption is framed more clearly around the authority of the medical practitioner. Medical perspectives tend to categorise consumption as either compliant to medical instruction or not. Investment in medical authority is most clearly framed through use of terms that specify deviation from direct medical instruction, like ‘non-compliance’ and ‘non-adherence’ (Fischer et al., 2010). Use of the terms ‘non-compliance’ and ‘non-adherence’ place the medical professional and the patient in a power relationship of clear dominance and subordination. Practitioners in the field of (drug) dependence treatment also utilise this kind of framework through reporting on the ‘misuse’ of opioid substitution medications such as methadone (Winstock & Lea, 2010). A conservative approach to the adherence to medical instructions is often articulated as essential to the effective delivery of these kinds of drug treatment services.

There are also important ways in which medical authority is embedded in the definition of terms that relate to health outcomes. As defined by a NDARC report, the term ‘harmful use’ refers to “a pattern of

drug use that is causing negative impacts upon health and may have negative social consequences” (Degenhardt et al., 2007: viii). The report does not define what it means by harmful ‘impacts on health’. The term ‘harmful use’ is however most often used when referring to IDU and HIV and other disease transmission. It is telling that ‘harmful use’ comes to describe IDU and HIV transmission in this literature, because both are marked by histories of highly moralised medical discourse (Dyson, 1992; Rhodes et al., 2005).

There are also important moral connotations that apply to the identification of and attempts to calculate ‘negative social consequences’, especially when presented as an indication of health. What constitutes a ‘negative social consequence’ varies considerably according to which social group one is referring to. A comparison to the criteria of ‘social impairment’ for the psychological diagnosis of ‘substance use disorder’ (SUD) (2013) is salient. Fraser and colleagues have argued that clinical reference to the ‘social’ often involve:

a hierarchical ranking of pleasures, in which family life and wholesome pursuits (assumed to be accessible and appealing to all) are placed above solitary consumption or the wrong sort of friends (Fraser, Moore & Keane, 2014: 42)

These are assumptions about socially and culturally specific contexts that are far from the goals of objective clinical discovery. Use of ‘social harm’ in epidemiological research also conflates the harms of criminalisation with

the harms of drug use. Terms such as ‘harmful use’ potentially ignore the social complexity of drug use in favour of a privileging of medical authority, and its apparent ability to determine what kinds of sociality are appropriate. As is also clear in the literature about IDU and HIV transmission, non-adherence is often thought of as unsanctioned, and consequently can come to be understood as a form of morally contentious or even criminal behaviour.

A focus on doctor shopping and inferences of diversion, non-adherence and its apparent harms, are also inadequate for any serious discussion of the way OTC medications are consumed. It is not a crime, nor necessarily medically negligent to purchase OTC medications and offer them to family members and friends. Moreover, very little scrutiny is expected of the consumption of OTC medications once they have been purchased. For instance, it is common for a workplace to have a communal medicine cabinet, likely to be comprised of OTC medications.

In a chapter of the *The Drug Effect* (2011), Keane draws on the work of Rose to observe how, through exposure to the biotechnological advances of the past fifty years, the modern citizen operates in “biological styles of thought” (Keane, 2011: 117). The chapter articulates how working environments increasingly position ‘underperformance’ as the product of sleep deprivation and attention deficit hyperactivity disorder (ADHD), and thus it is often medicated. Keane notes how this process forms part of “twenty-first-century styles of medical thought [that] move beyond a concern with health and disease to the goal of optimisation” (Keane, 2011: 107). While Keane discusses medications prescribed for sleep deprivation

and ADHD, her work provides important frameworks for addressing the use of OTC medication for the goal of productivity. It is unclear how the use of OTC medications for productivity would be considered under the SAMHSA definition of non-medical use and the terminology that has accompanied it.

Framing 'legitimate' consumption around compliance also ignores developments in aspects of the health and medical perspective over the last fifty years. The emergence of the patient's rights movement and neoliberal health policies that encourage self-care contribute to the way people consume their medications. The term 'extra-medical use' is perhaps the most interesting in this respect. Extra-medical use most often refers to consumption "without a prescription, but does not exclude the possibility that the user may have medically driven reasons for using the drug" (Degenhardt et al., 2007: viii). In particular this term helps to ameliorate some of the problems associated with determining that consumption of a drug for its 'experience' or 'feeling' is automatically entirely problematic. This term recognises that patients may determine their own health problem and are capable of (self)medicating with potentially therapeutic effect. Use of the term is however often limited to the pain medicine literature. Whether the discourse or practice of extra-medical use ameliorates the power imbalances in the doctor/patient relationship is less clear from observing the clinical literature. This question informs part of the empirical investigation in the next part of the thesis.

Research on non-medical use utilises a range of terms that are primarily based on the criteria set out in the SAMHSA definition. Terminology relating to the 'illicit' acquisition of pharmaceuticals often

conflates informal medication sharing with intention to profit from the on-selling of medications. Terms used to describe reasons other than medically defined benefit for consumption inscribe unrealistic distinctions between therapeutic outcome and pleasurable experience. The terminology described in this section informs much of how research on non-medical (ab)use is collected and disseminated. There is however another significant term, 'addiction', which is worth canvassing in detail for its influence on research about non-medical consumption. The next section discusses current professional debates about and diagnostic criteria for 'addiction'.

'Addiction' and the DSM-5

'Addiction' is a common concern of medical and psychological research about painkiller consumption. Clinical literature about non-medical use almost exclusively adopts a biomedical model of addiction based on the diagnostic criteria set out in the APA Diagnostic and Statistical Manual of Mental Disorders (DSM). There are however important debates about the biomedical and clinical definition of addiction that inform the criteria set out by the DSM, much of which is illustrated by changes implemented in the manual's latest incarnation, DSM-5. This section will provide an overview of the DSM-5s clinical approach to 'addiction' and its implications for studying painkiller consumption.

Released in May 2013 the latest version of the DSM introduces significant changes to the diagnostic criteria of substance related disorders

that have been hotly debated within the psychological community (Keane et al., 2011). The authors of the new manual emphasise that changes to individual disorders have been adopted in order to bring them in line with current research, and to ensure that the diagnostic criteria identify disorders with distinct underlying pathologies. Despite explanations about the importance of each disorder in the manual having a discrete neurobiological pathology, such considerations rarely form part of the diagnostic process outlined in the DSM-5 classification of 'addiction'.

The DSM-5 collapses its predecessor's categories of 'substance use' and 'substance dependence' onto a continuum of what is referred to as 'substance use disorder' (SUD). The criteria for SUD is also accompanied by clinical descriptions that refine the diagnostic process for individual substances. The manual therefore separates the use of individual substances into distinct disorders, such as 'cocaine use disorder', 'alcohol use disorder' and 'opiate use disorder'. Despite presenting the use of individual substances as discrete categories of disorder, the overarching diagnostic criteria for SUD is the same across all substances listed in the manual.

Subjective evaluation and reported behaviour remain central to, what the DSM-5 now terms 'substance-related and addictive disorders'. The diagnosis of SUD requires the observed or reported presence of at least two of the eleven available criteria. Much of this criteria relies on highly subjective observations about perceptions of 'impaired control', 'social impairment' and 'risky use', with only two relating to the 'pharmacology' of tolerance and withdrawal (APA, 2013). Fraser and colleagues have noted that:

SUD assembles diverse elements such as harms, risk, misuse of time, loss of self-control, pathological desire and biological disturbance into the condition of addiction and locates it in within the individual. However... the identification and evaluation of harm is not an objective or technical exercise as it involves judgements about what a meaningful and productive life looks like. (2014: 44)

These kinds of subjective judgements also extend to the prioritisation of medical authority in aspects of the SUD diagnosis. For instance, in the DSM-5 tolerance and withdrawal are no longer required for a diagnosis of SUD and their presence is instructed to be excluded if the patient is using opiates under the supervision of a medical practitioner.

A reduction in the centrality of tolerance and withdrawal from the DSM-5 diagnosis is closely tied to the rise of pain medicine. Pain medicine literature insists that pain patients have been stigmatised because 'drug dependence' (tolerance and withdrawal) has been unnecessarily conflated with 'drug addiction'. Partly as a result of the interests of the specialty of pain medicine, the authority of the medical practitioner can be used to discount the only verifiable link to the neurological processes involved in the diagnosis of SUD. This effectively renders tolerance and withdrawal irrelevant to the SUD diagnosis when a patient's opiate use is being supervised by a medical practitioner:

The symptoms of dependence, withdrawal and tolerance, which used to be the markers of genuine addiction, have become polysemic signifiers whose meaning is dependent on the absence or presence of medical supervision. Medical authority renders them expected side-effects of treatment, while outside the clinical space, when combined with certain social realities, they become signs of compulsive and disordered desire. (Fraser, Moore & Keane, 2014: 48)

While the DSM-5 presents a clinical consensus surrounding a set of observable 'addictive' behaviours the diagnostic process it sets out seems to have little to do with the notion of 'drug addiction' as a disease entity, located in the neurobiology of people who use drugs.

Despite the limited capacity for the DSM-5 diagnosis to identify the neurological components of 'addiction', research that utilises its criteria often assumes the presence of a biomedical disease. This has important implications on the dissemination of research about people who use opiates. The potential for survey results about subjective categories of behaviour to be transformed into indicators of disease requires close scrutiny. The next section will discuss the way in which 'addiction' and related terminology is used in psychological research about non-medical consumption.

Psychiatric literature

In clinical research there are a series of psychiatric problems that are associated with non-medical use. Statistical data has apparently uncovered significant correlations between non-medical consumption and the 'abuse' of other psychoactive substances. The definitions used in clinical studies most often refer to DSM criteria for a range of psychiatric conditions, though much of the available research is based on the manual's previous incarnation, DSM-IV-TR. Studies that use DSM criteria often reproduce the presumption of disease that operates in references to 'addiction', conflating a range of psychiatric disorders. For instance, in a 2008 study on the non-medical use of PO, the authors make the following observation:

We have found a prevalence of past-year non-medical use of prescriptions opioids of 4.5% in a survey of... approximately 10 million people. Such use represents misuse of a controlled medication and raises concern of self-medication, illicit drug use, medication non-adherence, overdose and, of special concern, the potential transition to a substance use disorder. (Becker et al., 2008: 41)

In this study "[opioid] abuse and dependence were collapsed into one category since these conditions are clinically similar" (Becker et al., 2008: 40). Psychiatric concern about 'illicit substance use' and non-medical use are often conflated in the literature and terms such as 'abuse' and 'dependence' are commonly regarded as similar enough not to differentiate in the dissemination of results.

The distinction between ‘abuse’ and ‘dependence’ is largely unclear in clinical literature and the terms are often applied to the same behaviour. One study might consider non-medical use with the observation that “persons are classified with ‘abuse’ of a particular substance only if they are not ‘dependent’ on that substance” (Sees et al., 2005), another collapses the two altogether (Becker et al., 2008), and a third will declare both to be “illicit use” (Vivian et al., 2005). It is clear from observations such as this that the field is characterised by imprecision, and that the result of such inconsistency is the perception that non-medical use will inevitably lead to abusive/dependent behaviours. This inconsistency of terminology is highly problematic when considering that most studies rely on the definition of non-medical use provided by the SAMHSA in order to establish a link between consumption and disorder.

‘Abuse’ of and dependence on medications are not only thought of as psychiatric disorders in and of themselves, they are often also presented as symptomatic of other forms of psychiatric dysfunction. Anxiety in particular has been associated with non-medical use (Vivian et al., 2005). Again most studies refer to the DSM criteria for establishing the presence of symptoms of anxiety. The literature refers to strong “associations between lifetime anxiety and mood disorders” (Becker et al., 2008). One study’s definition of those disorders states that:

Generalised anxiety symptoms are defined as worrying a lot more than most people about everyday problems or being a lot more nervous or

anxious than most people for half of the past year or more. (Becker et al., 2008)

The ambiguity of this definition is problematic. What is absent from this definition, as it relates to the study of non-medical use, is any consideration that anxiety may be an inevitable and indeed expected response to particular contexts or lived experiences. Under the DSM's definition the material realities of the everyday circumstances that affect people who use medications are substantially rendered irrelevant. The assumption is that if study respondents demonstrate symptoms of an anxiety disorder, they confirm clinical observations about connections between non-medical use (or substance use more generally) and psychiatric dysfunction. The potentially confounding influence of additional factors (for example, chronic pain or a stressful life situation) that may be producing anxiety and also act as motivators for non-medical use is ignored.

It is important to recognise that affective responses, like anxiety, are not simply biologically but also socially and culturally produced (Dertadian, 2011). This point will be elaborated on in the next chapter, by describing how the conditions of late-modernity are associated with feelings of insecurity, uncertainty and anxiety. The attribution of psychiatric dysfunction to presentations of anxious behaviour, and consequent attempts to pathologise and then medicate anxiety, overlooks the arguably widespread social, economic and political antecedents to anxiety. As was noted in Zinberg's classic study of heroin consumption, drug use cannot be reduced to its psychology, nor indeed to its pharmacology or sociality alone

(Zinberg, 1986). Drug use involves a negotiation of these three factors; the drug (and its pharmacology), the set (mood or mindset of the individual) and the setting (or social context). This approach has been influential in qualitative drug research since the 1980s. Following Zinberg, traditions of sociology and criminology have described how the psycho-pharmacological components of drug use are socially and culturally mediated (Moore, 1993).

The context in which people consume their medications is absent from much of the influential clinical literature produced by North American research. This presents a series of problems with the resulting data. The field is entirely inconsistent in its use of 'addiction' and related terminology. This is problematic because conflation between medication 'use', 'abuse' and 'dependence' leave the impression that any form of non-medical consumption is potentially pathological. Survey results that may be capturing informal medication sharing and the pleasurable aspects of pain relief are subsequently disseminated as indicators of levels of psychiatric disorder. Similarly, the literature's discussion of anxiety presents decontextualized accounts of non-medical consumption that are presented as symptomatic of psychiatric dysfunction. These pathologising processes have established an overly simplified mechanical relationship between reports of anxiousness and psychiatric illness. The next section moves to specifically discuss the Australian research context and its own articulation of pathologised discourses of medication 'abuse'.

People who inject drugs and the IDRS

Research specific to the Australian context is less extensive than the American literature, and tends to focus on people who already engage in 'substance use'. Most of the Australian data is collected as part of broader studies on alcohol and other drugs (AOD). A small group of researchers based primarily at NDARC have sought greater consistency of terminology for research on non-medical use. A 2007 report from NDARC notes that "misuse', 'non-medical use' and 'extra-medical use' are often used interchangeably in practice" (Degenhardt et al., 2007: viii). A 2011 review of the literature advocates for a narrowing of the terms used in research contexts to minimise the ambiguities that can result from the inconsistent application of terms (Larance et al., 2011). Larance and colleagues recommend that consistent terminology will produce less problematic results and allow for a broader application across multiple disciplines. Attempts to consolidate the field in this way are illustrative of a prevailing abuse/illicit understanding of practices of non-medical consumption in the Australian research context.

Two annual national projects and one tri-annual national study on drug use have introduced questions about non-medical use. The data from these three national studies makes up the majority of Australian data. This section will focus on the most influential annual study, conducted by NDARC. The Drug Trend Group at NDARC collects a significant set of data through its flag-ship project, the Illicit Drug Reporting System (IDRS). Funded by the Australian Government's Department of Health and Ageing

and the National Drug Law Enforcement Research Fund since January 1997, the IDRS produces an annual report. The survey component of the IDRS sample is solely comprised of PWID.

As a data source for non-medical use, the IDRS disseminates the findings of survey questions about the price and availability of pharmaceuticals reported to be purchased 'illicitly'. The IDRS consistently reports that the most common method for the 'illicit acquisition' of methadone, buprenorphine, buprenorphine-naltrexone, morphine and oxycodone is through a friend – usually representing approximately half of the responses (Stafford & Burns, 2010, 2011, 2012). The second most common method reported is through a known dealer, which amounts to approximately one quarter of the responses (Stafford & Burns, 2009, 2010, 2011). According to the 2011 IDRS survey participants primarily reported that OST medications – methadone, buprenorphine and buprenorphine-naltrexone – were either 'easy' or 'very easy' to acquire 'illicitly' (Stafford & Burns, 2012). With regard to prescription painkillers – morphine and oxycodone – only slightly less of the respondents reported 'easy' or 'very easy' access, while many more reported access as 'difficult' (Stafford & Burns, 2012). Across all of the pharmaceuticals investigated in the IDRS a fairly consistent observation has been the stability of an 'illicit supply' in street-based drug markets.

The project also investigates the 'illicit consumption' (intravenous use) of a range of pharmaceuticals. Morphine is the pharmaceutical most commonly reported to be injected by the IDRS sample, with the highest reported rates in the Northern Territory and Tasmania (Stafford & Burns,

2011). Approximately half of the national sample reported recent (in the past six months) consumption of a pharmaceutical opioid. Of those who reported recent PO consumption, half reported their use as related to pain, while a third reported seeking an opioid effect (Stafford & Burns, 2011).

Due to a series of associated health concerns, there is a great deal of significance given to this kind of cataloguing of reported rates. However, by focusing exclusively on IDU there is a broad range of people who use drugs that are excluded from the IDRS sample. The association between IDU and 'illicit consumption' is a powerful one in Australian culture, and its deeply moralised image often overshadows other forms of drug use (Moore, 2004). In the case of non-medical use, the IDRS potentially overlooks those who crush and snort their pharmaceuticals, or people who bite down on the drug, even those who let it dissolve under their tongue or just swallow it whole.

The dissemination of IDRS data involves a set of language that is also necessary to unpack. The 2011 report utilises six distinct phrases to discuss pharmaceutical consumption among its sample: use of licitly obtained opioids; use of illicitly obtained opioids; use of any opioids; injection of licitly obtained opioids; injection of illicitly obtained opioids; and injection of any opioids (Stafford & Burns, 2011). This language defines 'illicit' activity with pharmaceuticals in broad ways that are absent of contextual considerations. For instance, a report on IDRS data states "'Licit' refers to drugs that were prescribed directly to the participant, while 'illicit' refers to drugs that were directly prescribed to another person" (2012: 14). It is thus important to note that references to 'illicit acquisition' of pharmaceuticals

include behaviours that may not typically constitute criminal activity. As well as indicating the purchase of pharmaceuticals 'on the street', the term 'illicit' may also encompass altered patterns of prescribed self-use and the use of pharmaceuticals prescribed to a friend or family member. Whether such an exchange with a friend or family member was voluntary is not considered. Use of the term 'illicit' here requires a significant assumption of deviance. As the IDRS literature moves seamlessly between references to acquisition and injection, observations about 'illicit use' of pharmaceuticals become blurred in the process.

Police detainees and DUMA

The second project that produces annual data about non-medical use is the Australian Institute of Criminology's (AIC) Drug Use Monitoring in Australia (DUMA). In partnership with the AIC, state police services, and local researchers, a pilot version of DUMA was run in 1999, based on a similar system in the US. DUMA currently collects survey data and urine samples from police detainees (persons in police custody but not charged or convicted of a crime) on a quarterly basis, at nine sites across the country. Despite specific survey questions that impose a framework of 'abuse', a series of reports from the AIC have presented non-medical use as a problem that emerges 'naturally' from the data.

Interpretations of DUMA data have produced observations about the majority of detainees reporting pharmaceuticals are either 'easy' or 'very

easy' to obtain 'on the street' (Ng & Macgregor, 2012). This is consistent with IDRS data suggesting that pharmaceuticals are readily available in illicit drug markets. Yet little is known about how and from what sources medications are being diverted into illicit markets (Rodwell, Ringland, & Bradford, 2010). Forged prescriptions and theft from medical facilities have been identified as contributing factors, but by no means account for how 'easy' detainees apparently report their 'illicit acquisition' to be (Rodwell et al., 2010). It is however important to note that the most common response by survey participants was still that they acquire their pharmaceuticals from friends or acquaintances (Ng & Macgregor, 2012).

The AIC also consistently report that non-medical use is more common among the DUMA sample than in the IDRS and broader population study samples (McGregor, Gately, & Fleming, 2011). Female detainees commonly report higher rates of non-medical use than male detainees (McGregor et al., 2011). Benzodiazepine use in particular is thought to be highest among female detainees (Loxley, 2007). This is largely consistent with data about women in prison apparently having higher rates of drug use than their male counterparts (Butler et al., 2003; McClellan, Farabee, & Crouch, 1997). It is however worth noting that samples of police detainees are not representative of either the general population or the criminal offending population.

Research suggests that the high visibility of disadvantaged populations in the criminal justice system means that they are more likely to come in contact with police and to spend more time in police custody (Smith & Visher, 1981). Of particular controversy in Australia is the unequal time that

indigenous people spend detained in police custody uncharged (Cunneen, 2005). Heavy alcohol use (Weatherburn, 2008) and other forms of illicit (in particular injecting) drug use (Maher & Dixon, 1999) also increase the likelihood and frequency of being detained by police. Moreover, the results of a survey conducted in the highly pressured environment of arrest must be approached with a degree of scepticism. The arrest and processing of detainees has also been described as an important element of the punishment of those accused of a crime (Feeley, 1992). The potential for detainees to feel compelled to appear co-operative, and to produce answers that perform that co-operation is worth noting.

Given that social disadvantage shapes people's contact with the police, and the atmosphere of bewildered duress that characterises the arrest process, it would seem rather unsurprising that AIC researchers found that:

Among the detainees surveyed, more prescription drug users were unemployed, derived their income from welfare or benefits, considered themselves drug dependent, were currently on a drug-related charge and had been arrested or imprisoned in the previous 12 months by comparison with non-users (McGregor et al., 2011: 5).

Research suggests that samples of police detainees will be skewed towards very particular profiles of social disadvantage: thus it is clear that DUMA is not a generally representative sample the wider population. The project claims to provide information about connections between the criminal offending population and drug use, yet the data produced still only

represents those who are in police custody, not people who have been convicted of a crime. A collapsing of the categories of police detainee and convicted criminal is not explicit, but it is suggested in the literature produced by the AIC.

Decontextualised observations about non-medical use and ‘illicit activity’ are deployed in particularly problematic ways in the DUMA literature. As part of the project DUMA also performs urinalysis tests on detainees who have apparently volunteered to participate. In the case of opiates, a positive urinalysis reading is sent for further testing to distinguish between heroin and other opiates (codeine and morphine). In a section analysing urinalysis results and charges laid among detainees at Bankstown, the authors of the 2009-10 report write: “Property offenders, drug offenders, road and traffic offenders and breach offenders all had higher rates of opiate use than benzodiazepine use. The opposite was true for violent [and] drink driving [offenders]” (Sweeney & Payne, 2012: 46). The report presents a ‘statistically significant’ connection between positive urinalysis tests for opiates/benzodiazepines and criminal offences such as property damage, unsafe driving, violence and other forms of drug use. Claims about the connection between non-medical use and crime are however particularly limited because, as the methodological explanation of urinalysis in the report suggests, “a positive result does not necessarily imply illicit use” (Sweeney & Payne, 2012: 136).

References to ‘illicit opiate use’ are thus also particularly vague in much of the reporting of DUMA data. In a broader paper on drug use and property offending, Bradford and Payne name “self-reported days of illicit

opioid use” (Bradford & Payne, 2012: 3) as a primary variable of interest. The paper defines ‘illicit opioid use’ as including “heroin, morphine, oxycodone, street methadone, or other illicit opioids” (Bradford & Payne, 2012: 3). With definitions of ‘illicit use’ such as the ones described above, the literature suggests a conflation of what have previously been considered distinct medical and criminal forms of drug use. Though the collapsing of criminal and drug using behaviour is by no means a new phenomenon, the vagueness with which projects such as DUMA refer to ‘illicit pharmaceutical use’ introduces a new level of concern.

National data and the NDSHS

The necessity of large national projects that focus on ‘illicit contexts’ are consistently justified by the suggestion that they provide knowledge on a group that is of particular significance to the wider public. According to the NDARC website the IDRS is “intended to serve as a strategic early warning system, identifying emerging trends of local and national concern in illicit drug markets” (NDARC, 2013). Explanations of the project from a range of other institutions also tend to emphasise the ‘strategic’ nature of the project (Darke, Hall, & Topp, 2000). An AIC report indicates that DUMA seeks to provide knowledge on the very specific cross-section of ‘drug users’ and ‘criminal offenders’, because they apparently “have a greater impact on the quality of life of ordinary Australians than other groups of drug users” (Makkai, 1999: 23). The language that surrounds explanations of both the

IDRS and DUMA reveals a problematic emphasis on criminality, which is justified by presenting it as a 'strategic' focus on a population with 'greater impact' to the wider community.

Despite explanations of strategic value, the literature produced from the IDRS and DUMA seems to suggest a conflation of drug use and criminality. Though PWID and people who are alleged to have engaged in criminal activity are significant research foci, the "great majority of people who use drugs never come to the attention of doctors, lawyers, or policemen" (Robson, 2009: 18). It is thus entirely problematic that annual national data is only limited to criminalised contexts that are not representative of the wider drug using population. While the IDRS encompasses more epidemiological perspectives, it does so exclusively in a criminalised context that uncritically embraces stereotypical constructions of PWID and people who are drug dependent. Conducted in conjunction with police services and researchers who identify as administrative criminologists, the DUMA project goes even further, actively perpetuating an assumed connection between crime and non-medical use.

Annual national data largely limited to quantitative methods for examining criminalised drug markets provides fertile ground for the proliferation of correlative associations between drug use and crime. Without any significant avenue for critically exploring the validity of any causal link between non-medical and criminal forms of drug use, the current national context seems to be producing problematic knowledge about non-medical consumption. As the literature itself reveals, such projects are unable to provide detailed explanations of the practices being surveyed. In

fact a description on the NDARC website states that the “IDRS is designed to be sensitive to trends, providing data in a timely manner, rather than describing issues in detail” (2013).

The limitations of annual national data are not exclusive to the IDRS and DUMA. The National Drugs Strategy Household Survey (NDSHS) produces a tri-annual report funded by the Australian Institute of Health and Welfare that also provides a significant set of data on non-medical use. The NDSHS survey is sent out to a representative sample of more than 25,000 Australian households, and comprises people aged 12 and older.

Across the last four NDSHS reports there have been a series of findings about the use of pharmaceuticals for non-medical purposes that have remained largely consistent (Australian Institute of Health and Welfare, 2005, 2008, 2011). Of all the pharmaceuticals used for non-medical purposes, painkillers/analgesics are consistently found to be the drugs most likely for respondents to have consumed, followed by tranquillisers, barbiturates, benzodiazepines and sleeping pills (2011). NDSHS data suggests that those who use painkillers/analgesics for non-medical purposes are most likely to be aged between 20-29 (Australian Institute of Health and Welfare, 2008, 2011). There have also been slight variations in recent and lifetime use between genders in NDSHS data – men report higher rates of non-medical use over their life-time, while recent use is reported as essentially the same across genders (Australian Institute of Health and Welfare, 2008, 2011). According to the most recent NDSHS report (2010), just under one third of those who consumed pharmaceuticals for non-medical purposes said they used pharmaceuticals once or twice a year,

while just over a quarter said they used pharmaceuticals daily or weekly (Australian Institute of Health and Welfare, 2011).

Though the NDSHS does not provide as regular a set of data as the IDRS or DUMA, it does have a more general focus on the consumption of any drug, including alcohol. The NDSHS thus obviates some of the methodological limitations of national data collection. However while a household sample does engage a broader cross-section of people who use drugs, there are still limitations to note; the research is conducted within a context in which pharmaceutical and (illicit) drug use are regarded as very different social practices. Consequently, the impact this has on sampling and questionnaire responses should be considered. The perceived value of much research into drug use seems tied to the assumption that such use is both a moral and health hazard. The 'illicit' perception of drug consumption is necessitated by a dominant moral code that constructs research into the practice to be proscriptive.

The implied safety that has come to be associated with pharmaceuticals thus makes non-medical use difficult to capture in a survey that deploys terms such as 'drug use' and includes questions about a range of illicit drugs. Pharmaceutical consumption is still thought of as 'safe', firmly embedded in medical conceptualisations of health. This provides a likely legitimising conceptual framework that excludes even the term 'drug use' from the vocabulary of how most people think about the use of pharmaceuticals. National projects with such a significant quantitative focus are therefore unable to unpack and address these limits. Current national projects can only produce trend information about well-established

populations of, what are often stigmatised communities of people who use drugs.

Diversion of treatment medications

The methodological limitations of large studies are likely to be reproduced in small scale studies if they draw from a common conceptual framework that is distanced from the widest forms of non-medical use. Much of the recent small-scale studies into non-medical use in Australia have focused on the diversion, and in particular the injection of opioid substitution treatment (OST) medications (Larance et al., 2011; Winstock & Lea, 2010; Winstock, Lea, & Sheridan, 2007). OST drugs are prescribed to medically maintain the physiological components of opioid dependence – mainly withdrawal. Given that OST patients are necessarily already struggling with dependence related issues, the non-medical use and diversion of their medication is likely to be higher than in any other population group. The argument here is not that research on the diversion of OST medications is not needed, but that research limited to this very specific practice is problematic if wrongly understood as reflective of broader aspects of non-medical consumption.

There is an understandable emphasis on intravenous use in research on the diversion of OST medications. This comes largely in response to a growing consensus that beyond physiological withdrawal, which OST attempts to address, people who are drug dependent often find it difficult to give up the ‘rush’ of injecting (Giddings, Christo, & Davy, 2003). Some

studies have suggested that injectable formulations of OST medications are an important next step for such treatment programs (Degenhardt et al., 2009). Though it should be noted that there is some contestation of claims about the 'rush of injecting' (Fraser et al., 2004). Current research continues to suggest that the most common source of acquiring diverted OST medications is through friends and acquaintances, making up the vast majority of responses given (Larance et al., 2011). In terms of prevalence, a recent Australian study reported that among those in buprenorphine treatment programs, approximately one third claimed to have non-medically used their prescribed dose and/or have been involved in the diversion of their medication (Winstock et al., 2007). For buprenorphine-naloxone, it is closer to just over one fifth of the study respondents (Larance et al., 2011). Conversely, among those in a methadone program (the most popular OST available in Australia) only a little over one tenth say that they have used the drug non-medically or have been involved in its diversion (Winstock & Lea, 2010).

Research into the injection and/or diversion of OST medications is focused on the harms and potential harms that surround the practice. Buprenorphine in particular has been identified as the OST drug most likely to be diverted (Winstock et al., 2007). Still, the harms associated with the injection of OST medications remains tied to a sample of people already embedded in criminal networks. In a 2005 study into the diversion of buprenorphine in Melbourne, the authors conclude that "recent buprenorphine injection was associated with the injection of other drug types, injection-related health problems, opioid substitution treatment and

involvement in crime” (Jenkinson et al., 2005: 200). A more recent study emphasises the role that improved policies might have “in reducing non-prescribed drug use and related crime, and in enhancing general health and psychosocial functioning” (Larance et al., 2011: 270).

Criminal activity is often included as one of the health concerns identified in this body of research with little critical discussion of structural and policy frameworks that criminalise PWID. A recent body of research has emphasised the importance of the environmental factors associated with the harms of IDU and includes those produced by its criminalisation (Rhodes, 2002). However literature about environmental interventions has paid less attention to the way criminalised cultures of IDU affect the intravenous use of pharmaceuticals.

While an emphasis on intravenous use of treatment medications is entirely appropriate when studying patients in OST, there is a range of methods of painkiller administration for which data is scarce. Australian research focuses on samples of PWID or on criminalised contexts in which IDU is more common. The data’s broad focus on IDU is unlikely to be representative of non-medical painkiller consumption in Australia. A lack of representative data about the range of practices that comprise non-medical use in Australia may be presenting a disproportionate image of pathology and criminality to those required to respond to non-medical consumption as a public health concern.

Policy responses to non-medical use

In January 2006 the Drugs and Crime Prevention Committee of the Victorian Parliament was asked to conduct an inquiry into the nature, extent and culture of the non-medical use of benzodiazepines and other pharmaceuticals in Victoria. The final report, titled *Inquiry into the misuse/abuse of benzodiazepines and other forms of pharmaceutical drugs in Victoria*, was delivered in March 2007. In the report's 'Forward' the chair of the committee Judy Maddigan writes:

The most telling part of our investigations was the realisation that many people within the community do not perceive prescription drug abuse to be a form of drug abuse. Consequently, they are unaware of the harms that are associated with the misuse and abuse of prescription medications... Challenging the culture of drug use and abuse and contesting ideas as to what does or does not count as a 'drug' is a very difficult task. (Drugs and Crime Prevention Committee, 2007: 2)

Under this model of concern about a 'hidden' but growing 'problem' of medication 'abuse' the regulation of pharmaceuticals was given national coverage after the Victorian Coroner John Olle called for a public health response in the form of real-time monitoring of pharmaceutical purchases.

In early 2012 Olle remarked:

Where prescription-shoppers are identified, they should in the first instance be directed to support services, with law enforcement only involved with persistent shoppers and/or those who are motivated by profit rather than drug dependence. (Dearne, 2012a)

Olle's remarks sparked debate about the appropriate policy response. This section discusses a range of trial and proposed monitoring systems to address the diversion and non-medical consumption of pharmaceuticals. It starts by addressing a pharmacy level amphetamine monitoring system called *Project STOP* that dates back to 2005. This initiative served as a forerunner to a broader Tasmanian system that has been recommended for a national roll-out.

One of the first campaigns to address issues surrounding non-medical use in Australia was the Pharmacy Guild of Australia's *Project STOP* initiative. *Project STOP* began on a trial basis in Queensland in November of 2005, before rolling-out a national scheme soon after. The initiative provided participating pharmacies with real-time monitoring of an individual's purchases of products containing pseudoephedrine. *Project STOP* requires consumers to provide identification so that their purchases can be tracked. The project is described as aiming to prevent "the use of pseudoephedrine based products to manufacture methamphetamine" (Pharmacy Guild of Australia, 2007). *Project STOP* places a focus on the use of certain pharmaceuticals as precursors for the manufacture of illicit drugs, maintaining conceptual distance between licit and illicit forms of the drug. The project claims to provide pharmacists with a tool to negotiate the

therapeutic needs of their clients, and in turn to determine whether or not they will sell to any particular customer.

The context in which the *Project STOP* initiative emerged is important to canvas. Thought to be in response to a 'heroin drought' since the mid-1990s, increases in the importation and domestic manufacture of methamphetamine have sparked a range of public health and policy responses (Topp et al., 2002). During the early 2000s an increase in hyperbolic media coverage presented methamphetamine use as a 'new drug epidemic' (Ritter, 2007). Despite the identification of a 'subculture' within motorcycle clubs – self-described '1 percent bikers' or 'outlaw motorcycle clubs' (Barker, 2010) – exaggerated media reporting readily accused generic 'bikie gangs' of being responsible for perceived increases in methamphetamine use. As part of apparent efforts to address the 'amphetamine problem' a set of supply-side prohibitionist oriented policy initiatives were introduced in the mid-2000s (Groves & Marmo, 2009). *Project STOP* was born out of the heightened politically atmosphere surrounding methamphetamine at the time. It is worth noting that the shadow of a moral panic about a 'new epidemic' of 'illicit drug abuse' informed the first response to issues surrounding the diversion of pharmaceuticals, and the foundation of a proposed national system.

In 2012 Olle's calls for real-time monitoring was realised through an online system rolled-out across Tasmania. Developed as part of the state's Drugs and Poisons Information System, pharmacists were required to register clients and their purchases through Online Remote Access (DORA)

software. Though DORA was applied to a broader range of pharmaceuticals, it was largely based on the software used for *Project STOP*.

Unlike *Project STOP* however Tasmania's DORA system was presented as a tool to identify 'doctor shopping' and 'diversion', as well as to address the potential for non-medical pharmaceutical use. The DORA system has even been presented as an initiative in Australia's apparent 'war on drugs'. In a radio segment for *936 ABC Hobart* titled "Tasmania taking the lead in the war on drugs" the program was introduced as follows: "The latest illicit drug trade may be right under your nose and Tasmania is taking the lead in tackling it" (Brown, 2012). In early 2013 then Federal Health Minister Tanya Plibersek announced 5 million dollars of funding for the establishment of a national system for the Electronic Recording and Reporting of Controlled Drugs (ERRCD) that was to be based on the DORA system (Dearne 2012). Despite some questions about the technological capacity of the new software (Dearne, 2012b), in principle the proposed system would provide the kind of national real-time monitoring that prescribers and dispensers have been calling for. In response to three overdose deaths in a period of three months in rural NSW the Australian Medical Association reiterated the apparent urgency of a national roll-out (Kaye, 2013).

There is however several potentially problematic elements of this kind of register and track approach that state and federal governments seem invested in. The registration of pharmacy clients and their purchases has the potential to act as a punitive form of social control. An assumed advantage of the system is that clients wanting to avoid registered purchases will be encouraged to pursue alternative treatments for pain relief. Yet this touted

benefit ignores the related implication that clients may opt for lower potency pharmaceuticals, and therefore have less effective therapeutic outcomes, in an attempt to avoid registered purchases. Patients may also feel encouraged to alter the prescribed use of medications that are more difficult to acquire.

An important comparison is also found in the way registered clients and monitored purchases might resemble aspects of the concept of 'liquid handcuffs', which is used to describe the overly punitive elements of methadone services (Smith, 2011). Several methadone services attach a range of conditions to access to the medication that impose models of discipline on the client. Some methadone prescribers do not allow clients to collect their dose accompanied by friends or family members, and reserve the right to refuse sale if the client is not presented appropriately (i.e. neat clothing and grooming) (Fraser & valentine, 2008). The potential for similar restrictions on other medications monitored under the proposed system is worth noting. Lastly, unnecessary monitoring may potentially result in those simply altering their medical treatment being funnelled into drug treatment programs. Misunderstandings between clients and dispensers about the nature of multiple prescriptions will likely identify a range of 'serial shoppers' that, under the proposed ERRCD prescribers and dispensers' will have little choice but to refer to law enforcement.

A national roll-out of the ERRCD will effectively formalise the discourses of 'abuse' and 'illicit' activity that dominate the literature about non-medical consumption. The potential to transform creative medication consumption into a 'substance use problem' requiring treatment, as well as

the possibility of criminalising consumers who resist problems in the system, are important to consider. Much like the research literature canvassed throughout the chapter, the kinds of policy responses outlined in this section reveal a trajectory of prohibitionist policies that are likely to pathologise and criminalise the people who come in contact with them.

Variation in research perspectives

There is a distinct lack of consensus among those who research non-medical use. Though non-medical consumption is consistently framed as a practice of 'abuse' there are noticeable variations in the accounts found in pain medicine, psychological communities, AOD research and policy platforms. This is illustrative of the multiple and contested space that non-medical consumption occupies.

Pain medicine in particular has emerged as a significant contributor to research about non-medical use. Pain medicine has tended to use terms that carefully separate the moralistic implications of criminality and dysfunction from the development of dependence in clinical practice. For instance pain medicine is the only approach likely to make extensive use of the term 'extra-medical use' (Degenhardt et al., 2007). The role of pain medicine in advocating the continued use of opioid analgesics for pain relief will be canvassed in more detail in the next chapter.

A range of mental health researchers also focus on non-medical use, perhaps reflecting the growing influence of psychopharmacology and a

growing tendency to medicate psychological distress. Psychological research tends to focus on correlations with diagnostic criteria and therefore is most likely to use terms like 'recreational' or 'dependent use' (Davey et al., 1995). The work of practitioners in the field of drug dependence treatment is also significant. It is worth noting that studies into the apparent misuse of OST medications have a potentially significant bearing over the availability of AOD treatment options. Importantly, AOD researchers form a significant component of the Australian literature.

Australian research into non-medical use has begun to embrace an uncritical general correlation of non-medical use and patterns of criminality. The Australian research context reveals little deviation from the targeting of marginalised populations. Projects like IDRS and DUMA use a sample that is skewed towards young, Indigenous and low-socio-economic status Australians. Current research also remains focussed on PWID, ignoring a range of other non-medical practices.

The approach taken in Australian research is illustrative of the tendency towards positivism in drug research more generally. This literature's focus on a discourse of 'abuse' provides a limited capacity to define the disparate set of practices that make up non-medical consumption. Attempts to reconcile a diverse set of research in order to distil a singularised practice that can be 'properly' captured by survey results assume that non-medical consumption is characterised by practices of 'abuse'.

This variation in the research literature has important implications on policy responses, which often require a coherent 'concern' to respond to.

Conflating the variations found in the literature has resulted in simplifications that reduce approaches to non-medical consumption to notions of 'abuse' and thus the frameworks that dominate illicit drug policy. Policy mechanisms that only address the supply of drugs deemed (potentially) dangerous are likely to impose a framework of criminalisation onto practices of self-medication. This broadly prohibitionist approach is what informed the establishment of contemporary illicit drug policy, and the criminalisation of populations of people who use drugs (Douglas & McDonald, 2012).

Conclusion

This chapter has outlined the emergence of a discourse of 'abuse' surrounding non-medical consumption. It has explored how a range of research communities have sought to make scientific claim on the practice of non-medical consumption, purporting to have 'discovered' and began to 'measure' a 'new drug problem'. The construction of this 'new drug problem' is informed by data that often conflates practices of informal medication sharing with the intention to divert medications into illicit markets. While research communities have demonstrated an apparent consensus on a discourse of 'abuse', there is little consensus on the meaning and measurement of this 'abuse'.

So far this thesis has demonstrated the social and political formation of discourses about drugs and their 'misuse' or 'abuse'. The previous chapter

outlined the social history of Australia's approach to drugs and the unstable distinctions it formed between 'licit' and 'illicit' forms of opiates and other drugs. This chapter outlined a shift in the way this distinction is produced, revealing a preoccupation with medical authority. Through attempts to reproduce the importance of medical compliance, 'illicit' enactments of the painkiller now form the foundation of research literature about non-medical consumption. However this literature has ignored the social significance of the specific drugs being consumed and the context in which they are used.

Part Two will address gaps in the literature through an empirical investigation into a range of contexts of painkiller consumption. Before arriving at an empirical assessment of user perspectives it is however important to first explore cultural understandings of pain and the social meanings attached to the consumption of pain medications.

Chapter Four – Medical, social and commercial approaches to pain

Pain is a universal human experience. It is an inalienable part of the human condition. The way pain is defined, experienced and understood is however influenced by the discourses used to articulate it and the social conditions in which it is felt. This chapter considers pain from three key vantage points: as an issue within medical inquiry and treatment, as the main concern of an emerging field of specialist pain medicine, and as an expanding and increasingly commercialised category of discomfort and suffering in late-modernity.

Thus far Part One of this thesis has articulated the social construction of distinctions between kinds of opiates (and other drugs), and the political and professional interests that have informed them. Chapter Two outlined the significance of international influences and the rising prominence of the medical profession in the historical development of ‘licit’ and ‘illicit’ forms of opiate. Produced under a discourse about the ‘therapeutic’ or ‘abusive’ potential of each drug, medical authority became an important element of their continued symbolic separation throughout the twentieth century. Chapter Two described a shift in the way these distinctions, between the ‘licit’ and ‘illicit’ capacity of drugs, is being formulated in the twenty-first century. Among the contest of epidemiological, psychological and medical perspectives that have attempted to formulate a scientific body of research about non-medical consumption, it is largely regarded as ‘abusive’, and thus

as representative of a psychological or criminal pathology.

Whereas the previous chapters have contextualised the social and political histories that have informed drug consumption and the knowledge produced around it, this chapter focuses specifically on pain, its treatment, stigmatisation and commercialisation. It asks how contemporary understandings of pain contribute to the social, political and discursive context in which painkillers are consumed. The chapter starts by exploring the way general medicine conceptualises pain, before moving to discuss the emergence of the field of pain medicine and its approach to the neurology of the pain patient. It also explores the way neurological accounts from pain medicine have informed debates about 'addiction' and the social and emotional influences on chronic pain. The chapter also draws on theory from sociology and cultural studies to elaborate on the significance of the body and governance of the self as it relates to contemporary understandings of pain. This literature is used to consider the blurring boundaries between pain, anxiety and discomfort in consumer culture.

General medicine

The diagnosis and treatment of pain related symptoms and disorders forms one of the most contested areas of modern medicine. Among the contentious elements of the debate, the medical community seems to have come to the consensus that pain can be broadly divided into two categories: acute and chronic. Acute pain is most often defined by "its distinct onset, obvious

cause, and short duration” while chronic pain is usually defined by “its persistence beyond an expected time frame for healing” (Ferrell, 2003: 323-324). Chronic pain is a more complex phenomenon that is often regarded as difficult to treat. The speciality of pain medicine has shaped and been shaped by this distinction between acute and chronic pain. Rising interest in chronic pain within the medical profession, and the frameworks used to conceptualise its diagnosis and treatment, will be taken up in more detail in the next section. On the other hand, general medicine is typically concerned with issues of acute pain.

General medicine often conceptualises acute pain as a “warning system, as our body's attempt to draw attention to a body part that has been injured or that is in danger” (Northern Private Pain Centre, 2012). Most general medical practitioners who encounter acute pain thus often understand it to be *caused* by another underlying medical issue. The focus is understandably on correcting the underlying medical issue, in the informed hope that the pain will disappear accordingly: broken bones *cause* pain that fades as the bone heals; high fevers *cause* pain that diminishes as the fever subsides. The most common medical response to acute pain is the recommendation or prescription of analgesic medications. Within Australia, patent guidelines and Federal and State legislation regulate the availability of analgesic medications for prescription by physicians and OTC purchase by consumers.

Established under the *Therapeutic Goods Act 1989* the scheduling of drugs in Australia is overseen by the National Drugs and Poisons Schedule Committee (NDPSC). All Australian states and territories adopt the

substantive component of the scheduling system set out by the NDPSC, though slight jurisdictional variations do exist (The Royal Australasian College of Physicians, 2009). An assortment of low dose paracetamol, ibuprophen and codeine products are classified as Schedule 2 Pharmacy Medicines, while higher dose formulations of these substances, like Panadeine Extra (paracetamol and codeine phosphate) and Mersyndol (paracetamol, codeine phosphate, doxylamine succinate), are considered Schedule 3 Pharmacist Only Medicines. Tylenol (co-codamol) and Tramadol (hydrochloride capsules) are classified as Schedule 4 Prescription Only Medications and require professional medical monitoring. However most opioid (and analgesic) formulations are classified as Schedule 8 Controlled Substances, whose possession without permission is a criminal offence. Under NDPSC regulation 'permission' for access to Schedule 8 opioids can only be granted by a medical practitioner and for 'therapeutic purposes'.

One final opioid formulation called diacetylmorphine, commonly known as heroin, is a Schedule 9 Prohibited Substance. The sale, distribution, use, and manufacture (except for the purposes of research) of Schedule 9 substances is prohibited by law. While diacetylmorphine is prohibited in Australia it is available for analgesic purposes, such as the relief of chronic and malignant pain, in the UK and elsewhere (Van de Werf et al., 2003). Medical research about the analgesic capacity of diacetylmorphine is limited, with much of the medical literature focussing on its uses as a replacement therapy for people who have been in treatment for chronic relapsing opioid dependence (Clark, 2010; Nosyk et al., 2012).

Medical literature about analgesic medications does however focus on opioids more broadly. The medical literature divides opioids into three categories: opioid agonists, opioid antagonists, and opioid agonist-antagonists. Examples of opioid agonists include oxycodone and methadone. Opioid agonists are described as substances that attach themselves to and activate opioid receptors in the brain, which is what is thought to produce the analgesic effect (Berger, 2005). The activation of opioid receptors in the brain is the same neurological process that can result in the pleasurable or euphoric feeling of the opiate 'high' (Robson, 2009). Though a distinction is often made between analgesia and an opiate 'high', little is devoted to explaining this distinction. This may also be linked to a general avoidance of the discussion of pleasure in drug research (Fraser, 2008).

What explanations that do exist in the medical literature tend to describe the presence of physical pain and its alleviation through the activation of opiate receptors as what characterises the process of analgesia. The neurology of pain and its subsequent interaction with analgesic medication is not well developed in the literature. Rather than any neurological explanation about the assumed difference between analgesia and pleasurable inebriation the literature relies on descriptions about physical suffering and its alleviation through the activation of opioid receptors.

On the other hand explanations of opioid antagonists tend to describe a chemical substance that also attach to opioid receptors but do not activate these receptors. Opioid antagonists therefore block or reverse the effects of analgesia and respiratory depression. Opioid antagonists like naltrexone

and naloxone are most often recommended for overdose prevention (Sporer & Kral, 2007). Lastly, opioid agonist-antagonists are thought to attach to the same opioid receptors, activating some while blocking others. Drugs such as nalbuphine and buprenorphine are considered agonist-antagonists and descriptions of their use relate mostly to mild analgesia with limited respiratory depression and low levels of tolerance building (Stoelting & Hillier, 2012).

The principles that guide general medical approaches to pain are tied closely to the medications used to treat it. Legislative regulation and scientific accounts of analgesic medications often make reference to their appropriateness for the relief of acute and/or chronic pain. While pain relief is a common part of general practice, it is largely described as peripheral to the central role of general medicine, whose primary objective is to address the underlying condition. This is however not the case with chronic pain. Though the medical practitioner may often know the origins of chronic pain, the ongoing cause is rarely identifiable. The specialty of pain medicine came about largely as a result of rising interest in chronic pain, and has developed tensions with medical approaches to pain more broadly.

The evolution of pain medicine

The medical profession has long been concerned with an appropriate language to 'measure' pain (Meldrum, 2003). In a 1939 study, Dallenbach developed a series of 44 terms that attempted to categorise the temporal,

spatial, pleasurable, affective and qualitative attributes of pain (1939). In 1971 researchers at McGill University in Montreal recruited a panel of students, patients, and doctors to refine Dallenbach's classification of pain terms. The McGill Pain Scale, as it came to be known, divided the terms used to describe pain into three categories: sensory, affective, and evaluative (Melzack, 1975). The medical profession has since developed a range of other tools to 'measure' levels of pain including verbal, visual and numerical rating scales (Frampton & Hughes-Webb, 2011).

Despite a proliferation of tools of measurement, little consensus has emerged on the reliability of any one system of 'pain measurement' and the medical literature consistently comments upon the difficulty of its study and treatment: "Progress in measurement has been slow because pain is a complex perceptual experience that can be quantified only indirectly" (Chapman et al., 1985: 1); "attempts to make valid assessments of [pain] have been fraught with difficulties" (Briggs & Closs, 1999: 438); "Although certain physiological responses or behaviours prompted by pain may be observed, modern medicine has produced no single parameter to represent our understanding of what we know to be pain" (Noble et al., 2005: 14). The medical profession broadly views pain scales as problematic because of the apparent unreliability of a patient's subjective self-evaluation, at least as in comparison to ostensibly externally verifiable methods of testing such as biopsy or necropsy.

The development of the field of pain medicine has however been less concerned with the capacity to accurately 'measure' pain. Pain medicine developed rapidly as a field distinct from general medicine after a 1965

publication by Melzack and Wall that presented pain not only as the result of disease or trauma but as a medical problem in itself (1967). In this influential publication Melzack and Wall describe how the transmission of messages about pain to the brain could be both obstructed and facilitated by mechanisms in the dorsal horns of the spine. The gate control theory, as it came to be known, demonstrated that the transmission of such messages was based on the diameters of “active peripheral fibers, as well as the dynamic action of the brain process. As a result, psychological variables such as past experience, attention, and other cognitive activities have been integrated into current research and therapy on pain processes” (Melzack, 1996: 128). The significance of the gate control theory was that it challenged medicine’s then dualistic model of pain as either the body’s proportional response to tissue damage or the individual’s imagined experience (Meldrum, 2003).

Following the gate control theory the field adopted the perspective that pain is an “experience which can be reported only by the sufferer” (Noble et al., 2005: 14). In 1979 the International Association for the Study of Pain (IASP) developed the following definition, which is still in use today: “[pain is] an unpleasant sensory and emotional experience, associated with actual or potential tissue damage, or described in terms of such damage” (IASP, 2014). Due in large part to the development of the specialty of pain medicine, the medical profession more broadly began to acknowledge that pain is not merely a naturally occurring object that can be measured.

In March 2010 more than two hundred representatives from various health, consumer and industry groups gathered for the first time in

Australian (and international) history, for the explicit purpose of finding ways to improve the assessment and treatment of pain. The National Pain Summit, as it was referred to, produced a report that was to act as a guideline for the future of the speciality of pain medicine. The authors of the report reiterate the notion that pain is only subjectively verifiable: “all pain is an individual human experience that is entirely subjective and that can only be truly appreciated by the individual experiencing the pain” (National Pain Summit Initiative, 2010: 11). The task of the summit was to consolidate the field around ‘practical strategies’ for coping with individualised conceptualisations of pain.

The primary strategy endorsed by the summit’s final report was a biopsychosocial model for dealing with pain (National Pain Summit Initiative, 2010). Under the biopsychosocial model three key aspects of the patient are described as important, and they have been briefly summarised as “‘Bio-’ (what’s happening to the body)... ‘-psycho-’ (what’s happening to the person)... [and] ‘-social’ (what’s happening in the person’s world)” (Cohen & Wodak, 2012: 24-25). It is important however to recognise that, while the biopsychosocial model is endorsed by the specialty of pain medicine, general medicine has not taken to the approach quite as readily. Cohen and Wodak note that:

Although pain is appreciated conceptually in a ‘biopsychosocial’ framework that identifies semantic, psychological, societal and cultural contributions, the person in pain is still commonly processed through a narrow biomedical model, where the emphasis is on finding – and

treating – an underlying pathological condition that ‘causes’ the pain.
(2010: 10)

Tension between the biopsychosocial model and more conventional biomedical approaches are thought to be contributing to the medical profession’s stigmatisation of the chronic pain patient (Morgan, 2006: 38).

Despite this, pain medicine has maintained advocacy for the cautious use of opioid analgesics in the treatment of chronic pain. This has been the long standing largely consensus position of the speciality ever since an influential article on pain management by Portenoy and Foley in 1986: the article concludes that opiates are a “safe, salutary and more humane alternative to the options of surgery or no treatment” (Portenoy & Foley, 1986: 171). Continued advocacy for the use of opiates in the face of concern about their ability to be ‘abused’ often draws on neurological research about tolerance and dependence.

Distinctions between tolerance, dependence and ‘addiction’

As part of attempts to formulate a scientific literature to support a biopsychosocial model of pain and its treatment with opioid analgesics, pain medicine has drawn considerably from new neurological research. Since the early 1990s a focus on the molecular and intracellular elements in neurological research has been presented as a ‘cutting edge’ way to demonstrate the ‘plasticity’ of the human brain. Though different areas of

medicine and research have used the concept differently, neuroadaptation has been an important explanatory tool for pain medicine. Drawing from the concept of neuroadaptation, pain medicine literature has built careful distinctions around the 'addictive' capacity of opioid analgesics. This section will outline neurological research about tolerance, dependence and 'opiate addiction', as well as the way pain medicine borrows from and interprets this research.

Neuroadaptation is described as "the process by which the brain modifies its sensory input, in response to touch, heat, cold, pain, sight, sounds, or smell" (Kershner, 2008: 302). In neurological research the human brain is presented as having qualities of plasticity that render it susceptible to change in response to chemical stimulation (Hyman & Malenka, 2001). The neuroplasticity of the brain forms one of the central tenets of neurological accounts of 'addiction' as a brain disease.

A wide range of scientific communities (Vrecko, 2010) now advocate for a model of 'addiction' as brain disease. This approach is primarily based on explanations of the neurobiological processes involved in drug use. Changes in the brain brought about by the chemical stimulation of prolonged opiate use are thus thought to produce the disease entity of 'addiction'. This is made visible, and ostensibly measurable, through a series of biomedical technologies such as positron emission tomography and functional magnetic resonance imaging scans that purport to show addiction in particular colour patterns, contrasted with 'healthy' parts of the brain (Leshner, 1997; 2001).

The US National Institute on Drug Abuse (NIDA) is a pioneer of the addiction as brain disease model and information on its website describes addiction as a “chronic, relapsing brain disease” brought about by the way in which “drugs change the brain; they change its structure and how it works” (2007). Neurological models specifically locate addiction in the malfunctioning of the pleasure-centre of the brain. A distinction between ‘normal’ desire for the pleasurable effects of drug use and a ‘disordered’ pathological desire features prominently in the literature. There is however an unresolved tension in conceptualising the brain as having properties of plasticity and thus as always subject to change, and the assumption that contact with opiates and other drugs creates a neurologically fixed disease state (addiction). The literature only addresses these tensions by saying that addiction related changes to the structure of the human brain present as particularly persistent (Fraser, Moore & Keane, 2014).

While addiction science presents ‘drug addiction’ as a neurobiological brain disease, its capacity to describe the way such neurological processes translate into specific social behaviours is limited. This demonstrates some of the tensions between addiction science and its translation into psychological diagnostic tools like the DSM-5. Addiction science seeks to provide an account of the causal relationship between drug use and the brain disease ‘drug addiction’, but fails to provide an explanation of how such neurological processes become complex social behaviours. There are also important tensions between what neurological accounts of tolerance represent in different areas of medicine. Though tolerance and withdrawal

play less of a role in the DSM-5, they are still presented on a spectrum of mental disorder.

Pain medicine presents another account of the neurological process of tolerance due to prolonged opiate use. A basic consensus lies in the qualities of the neurological process of treating chronic pain with opiates, which is often described as such: “in the course of opioid treatment, the analgesic effects of opioids may show a decline with a given dose, or require a higher dose to produce an equivalent degree of analgesia” (Berger, 2005: 113). This need to increase dosage of opiates is commonly presented as a ‘red flag’ in addiction discourse (Fraser, Moore & Keane, 2014). However the pain medicine literature insists that an increase in dosage of opiates is ‘normal’ and entirely manageable through appropriate clinical practice (Cohen & Wodak, 2012). In such an account the physiology of drug tolerance is rejected as an indication of addiction. In saying so pain medicine has used the concept of neuroadaptation to, at least in part normalise drug tolerance in the context of the treatment of chronic pain (Rose, 2003).

Within pain medicine a series of terms have been developed to explain the neurological and behavioural consequences of prolonged opioid consumption among chronic pain patients. ‘Pseudoaddiction’ is used to describe drug-seeking behaviour as a result of the under treatment of pain (S.D. Passik & Kirsh, 2004). ‘Therapeutic dependence’ refers to similar behaviours produced by a patient’s fear of running out of their prescription or of a worsening of their condition (Littlejohn et al., 2004). ‘Chemical coping’ is used to refer to a patient who (ab)uses their medications non-medically in order to deal with stress and anxiety related to chronic pain

(Kwon et al., 2014). Thus, within the pain medicine literature 'true addiction' is "characterized by aberrant behaviour, craving and loss of control" and prescription opioids are therefore "not dangerous illicit substances but effective analgesics appropriate for long-term use" (Keane & Hamill, 2010: 58). There are however noteworthy tensions between the pain medicine literature's attempt to avoid use of the term 'addiction' because of its stigmatising qualities and the way in which chronic pain patients are stigmatised in medical practice (Cohen, Quintner & Buchanan et al., 2011; Holloway, Sofaer-Bennett, & Walker, 2007; Jackson, 2005).

The use of terms such as pseudoaddiction, therapeutic dependence and chemical coping also reify long-standing distinctions between the psychical and psychological components of addiction. The physiological/psychological distinction developed by psychiatrists during the 1920s reappears, albeit in a slightly different form, in much of the pain medicine literature. As discussed in Chapter Two the psychological/psychological distinction involves moral assumptions about people who have become dependent through 'legitimate' medical treatment and 'true addicts' who have become dependent through pleasure seeking. This literature also consolidates social distinctions between medical and criminal substances, licit and illicit opiates.

The distinctions between tolerance, dependence and 'addiction' presented by the pain medicine literature are held together by a faith in the medical profession and its role as an agent of social control. It is however worth noting that emerging concern about painkiller 'abuse' has somewhat challenged medicine's capacity for social control, leading to criticisms about

a liberal prescribing culture around opiates (Kalso, Hearn, & de Williams, 2010; Steven D Passik, Kirsh, & Webster, 2011). Despite concerns about the liberal prescribing of opiates, the medical practitioner still retains a key social control element in much diagnostic practice. As noted in the previous chapter, the DSM-5 also upholds these distinctions by excluding tolerance and dependence as criteria for SUD if they present as part of treatment for chronic pain. Neurological research plays an important part in the changes made to the DMS-5. However, as this section has already indicated, there is a range of applications for neurological accounts of the plasticity of the human brain.

The neuroscience of pain

Neuological research has also been influential in other areas of pain medicine and research. The term neuroadaption has been used to refer to the way in which the experience of prolonged pain itself alters the functioning of the brain. Neurological research has helped build a scientific literature around the biopsychosocial model endorsed by pain medicine. Presenting psychological and social experiences as part of a process that alters the patient's brain provides a more recognisable medical narrative that returns to material, and thus ostensibly measurable components of the body. However pain medicine does not support any sort of consensus on the notion that neuroadaptive pain should be understood as pathological (Tracey & Bushnell, 2009). Rather, much of the literature suggests that,

much like drug tolerance, it is simply a 'normal' neurological response to the experience of intense pain (Post, 2002).

The neurological focus of the speciality has produced observations about the similarities of chronic pain, sustained opiate consumption and prolonged mood states such as depression and anxiety (Bair et al., 2008; Eisenberger, 2012). Medical literature has long acknowledged a statistical association between chronic pain and the development of depression and anxiety (Fishbain et al., 1997). Similar observations have been made about physical and mental health more generally. A 2007 article in the *Lancet* on the global state of mental health states:

The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. (Prince et al.: 859)

The connection between mental and physical health is also associated with social status. In a report commissioned by the Government of the United Kingdom, the authors state:

Mental health problems can also contribute to perpetuating cycles of inequality through generations... Many mental health problems start early and are associated with a number of known risk factors, including inequality. (HM Government, 2011: 9-19)

Indeed it is a consistent finding across an extensive breadth of research that social status (low levels of income, positioning within minority communities, etc.) is associated with a less robust physical condition as well as adverse psychological states (Teesson et al., 2011). While areas of medical and epidemiological research have demonstrated links between physical, psychological and social health outcomes, new neurological research has begun to note similarities in the neurological processes involved in physical, emotional and social forms of pain.

Consistent neurological reports that social (which involves emotional) and physical pain share similar neurological mechanisms (MacDonald & Leary, 2005) is of significance. Neurological research has compared brain activity when exposed to physical injury and emotional anguish, finding noteworthy similarities. Studies using functional magnetic resonance imaging (fMRI) claim that “certain human brain areas that ‘light up’ during physical pain are also activated during emotional pain induced by social exclusion” (Panksepp, 2003: 237). A recent study extended observations using fMRI by testing the “dorsal anterior cingulate cortex, anterior insula and operculum, and secondary somatosensory cortex and dorsal posterior insula individually”, finding that “[e]ach region was activated by social pain” (Wager et al., 2013: 1395). Such neurological accounts have led researchers to posit that “social and physical pain might rely on overlapping neural processes in the form of a common neural alarm system” (Eisenberger & Lieberman, 2004: 298). Within pain medicine literature neurological accounts of ‘social pain’ provide a biophysical explanation for statistical

links between physical, emotional and social health. This aligns closely with the biopsychosocial approach and its focus on treating the biological, psychological and social factors of chronic pain as intimately related.

Neurological accounts of pain raise questions about the nature and experience of pain, which cannot be reduced to a simple matter of torn or damaged tissue. Specialised medical literature presents the experience of pain as subjectively verifiable. Widely accepted medical definitions of pain no longer require the verification of tissue damage, and now include human experiences that are simply described in such terms. Developments in the neurological sciences have seen the principles of pain medicine extended to experiences of social exclusion and the emotional responses that accompany it. These developments reveal an expanded definition of pain in medical discourse and its conceptualisation of the health and illness of the human body. In order to better conceptualise the relationship between the physical, psychological and social elements of pain the next section will canvass social science literature about the body.

The body in the social sciences

The relationship between the physical body and the social world has often been the subject of social science research and scholarship. Such research has demonstrated how social forces shape cultural understandings of the body. This section will outline social science literature about the medical perspective and the way it constructs the body, illness and pain.

In Foucault's work around the genealogy of the medical perspective he notes that its development in the eighteenth century relied on a construction of the body as either functional or dysfunctional (1994: 33). The identification of disease (or ill-health more broadly) relies on medicine's generalised understandings of what is 'normal' bodily functioning, and any deviation from this understanding of normative bodily function can be reduced to a pathological classification (Foucault, 1994). Describing acute pain as an *indicator* of injury or illness has important links to this traditional medical conceptualisation of the body. This approach informs general medicine's ongoing commitment to biomedical (as opposed to biopsychosocial) understandings of the patient, the body and pain.

Sociological interest in the body since the 1960s has built on Foucault's (1973) observation that twentieth century medical practice involved increased surveillance of the body, through the institutionalisation of routine medical exams and the establishment of the post-mortem and surgical fields. This work introduced a theoretical framework that presented the body to be the "ultimate site of political and ideological control, surveillance and regulation... thus rendering bodies productive and politically and economically useful" (Lupton, 2012: 25).

Reluctance to directly engage the body as a site of sociological interest can be largely explained by a desire to avoid a biological deterministic perspective. Sociology was founded on the notion that social structures (rather than biological factors) play determining roles in people's behaviour: "The legitimate rejection of biological determinism in favour of sociological determinism entailed, however the exclusion of the body from

the sociological imagination” (Turner, 2008: 61). There are however traditions of sociology that have long been interested in the medical profession and its conceptualisations of health and illness. The functionalist tradition of the sociology of health and illness established that the identification of disease and illness is a bureaucratic (Strong, 1979) and social process (Parsons, 1951), while Marxist traditions have emphasised the impacts of the inequalities produced by the capitalist economic system (Conrad & Schneider, 1980; Illich, 1976).

It was not however until Turner’s influential *The Body and Society* (1984) that a foundation for the sociology of the body was established. Turner elaborated on an understanding that the body (and its illness) is the subject of power relations: “The language of disease involves judgment as to what is desirable and undesirable, and the medical profession has in modern society enormous institutional purchase on what is to count as the good life” (Turner, 1984: 200).

The role of the patient in ‘confessing’ the diseased or unwell body is an important element of the sociological literature (Armstrong, 1983), and particularly resonant for interpretations of medical approaches to pain. It was in 1979 that the IASP created its definition of pain as a subjectively verifiable phenomenon within the medical clinic. The ambiguous relationship between the materiality of pain and representations of pain also haunts medicine’s inability to arrive at a satisfactory tool of ‘measurement’.

Scarry’s seminal piece on torture, *The Body in Pain* (1985), noted that unlike other bodily experiences pain has no external object: “Hearing and

touch are of objects outside the boundaries of the body, as desire is desire of x, fear is fear of y, hunger is hunger for z; but pain is not 'of' or 'for' anything – it is itself alone” (1985: 161-162). The absence of an external object makes pain unique from other human experiences, because it often defies expression, whether in individual or medical discourse. The struggle to find meaning in and proper expression for pain has since been the subject of critical theory (Morris, 1991), sociological inquiry (Illouz, 2013) and anthropological study (Good et al., 1994). In an investigation into the “uncertain geographies of pain” Bissel describes the multiple possible elements of material expressions of pain:

First, there is the affective force of the physical painfulness of the pain itself impressing through the body: the sheer bite of pain through the body itself... Indeed this might be supplemented by the communication of the 'bite' of pain through facial expressions and bodily comportments. But then there is the affect of the hospital that intensifies the embodied sensation of the physical pain, the clenched fists, the thumping of the heart, through its proximity. (Bissel, 2012: 81)

Bissel's account describes the way the body communicates pain, and the way representational systems ascribed to such expressions also inform the experience of pain.

The emergence of social constructionist accounts of the body since the 1980s forms an important part of the theoretical approach to the body and

tain in this thesis. While the body contains certain fixed capacities (such as height and bone structure), social constructionism has demonstrated that the body is also mediated by “certain kinds of knowledge and discourses which are subject to change” (Lupton, 2012: 23). The contributions of the sociology of health and illness, as well as the emergence of the sociology of the body, have helped to remake cultural understandings of the body. Social science research has demonstrated that there is an intimate relationship between the body and the social world. The way the body is governed is thus also an important area of social science literature on the body.

The governmentality literature has noted that since the 1980s medical and public health discourses have increasingly “emphasised [that] the mundane striving for ‘good’ or ‘perfect’ health involves intensive ‘work on the self’ or self-governance” (Petersen et al., 2010: 392). Castel’s work in the influential *The Foucault Effect* (1991) noted an important transition in neoliberal societies from forms of social control based on ‘face-to-face’ relationships with experts to those based on abstracted calculations of risk. Petersen extended these observations by noting that neoliberal modes of public health erode the distinction between sickness and health, replacing it with an “endless parade of ‘at risk’ populations and ‘risky’ situations” (1997: 195). Elements of public health have encouraged individuals to ‘take responsibility’ for the condition of the body by negotiating risks to their health (Petersen & Lupton, 1996).

A language of ‘empowerment’ plays an important role in the neoliberal philosophy about health. The modern subject is purportedly offered an abundance of health information, disseminated through public health

campaigns and websites, which are presented as ‘tools’ that empower the individual to ‘choose’ a healthy lifestyle. It is important to recognise however that an emphasis on risk and empowerment has not emerged as an organic progression of health discourse. Chapter Two has already noted that the responsabilisation of health in this way is linked to the commercial and class interests of the neoliberal project.

The role of the pharmaceutical industry and the biotechnology industry in promoting modes of preventative medicine cannot be overlooked in the rise of neoliberal governance through discourses of risk (Burrows, Nettleton, & Bunton, 1995). For most however self-governance of the body through the responsible management of risk appears as an elite ideal that is unachievable without considerable financial resources. The governmentality field has since developed a distinct scepticism of the notion that neoliberal approaches to public health provide any sort of genuine tool of a-political ‘empowerment’: “despite the language of empowerment and freedom, this striving for health entails compulsion, added responsibilities to others, and often punishment and social exclusion in the case of those who fail to conform” (Petersen et al., 2010: 392).

Applications of governmentality have produced a substantive body of scholarship politicising the neoliberal fantasy of ‘empowering individuals’ through ‘government at a distance’. As well as outlining the responsabilisation of health practice (Gray, 2009; Teghtsoonian, 2009), this literature has also demonstrated how neoliberal governance has been used to justify a retreat from the ‘welfare state’, seen most clearly through the privatisation of health and social services (Blomqvist, 2013; Larner, 2000).

Governmentality scholars have used ‘technologies of self’ as a way to explain the imposition of prevailing health discourse that demands the production of a more enterprising subject, in charge of his/her own health.

However much of this literature has been critiqued for providing a limited analysis of neoliberal governance, one that reproduces a top-down model of power by readily privileging ‘official’ discourses (O'Malley & Clifford, 1997) and thus discounting the constitutive role of resistance in Foucault’s original account of governmentality (Mckee, 2009). A balance needs to be struck between analysis of wider social structures and the individual bodies being governed. The remainder of the chapter will address the biopolitical arrangements that shape and impact the body in pain.

Anxious Bodies

Due in part to the ways in which bodies are governed in late-modern society, definitions of pain have been extended to include feelings of ‘anxiety’. Medical accounts of pain often incorporate notions of anxiety. Pain medicine literature includes explanations of pain patients who feel anxious about a worsening of their condition and who engage in anxious ‘drug seeking’ (Kirsh et al., 2007). The neurological literature often refers to ‘anxious attachments’ and their contribution to forms of social pain (Eisenberger, 2011). A range of pharmacotherapies, largely framed under a psychological paradigm, have also been developed over the last century to deal with a growing emphasis on anxiety.

However it is important to remember that a history of medical intervention into pain and its connection to anxiety may disguise the social determinants of 'feeling worried'. It is thus also necessary to consider the way social theorists have described the uncertain conditions of modernity, and how this contributes to people's bodily experiences of pain. The conditions of modern society shape the production of affective states and the manner in which they are experienced, labelled, understood and responded to individually and socially. This section will outline changes in modern society that may be fostering uncertainty and thus producing social and emotional 'worry' that is likely to be experienced and understood as *painful*.

Towards the end of the twentieth century social theorists have articulated a series of changes in the modern condition. The work of Beck, Giddens and Lash (1994) has argued that social relations are increasingly characterised by projections of future dangers and calculations of risk. In so arguing they describe, what is referred to as a transition from industrial societies to risk societies. The way in which modern societies encourage constant evaluation of possible risks is a requisite example of how the modern condition is implicated in notions of anxiousness. Salecl has more recently observed how contemporary capitalism relies on the anxieties of the consumer (2004: 30). Salecl argues that, within advanced capitalist economies, cycles of consumption rely on anxiety about 'proper' feminine appearance or middle class ideals of 'healthy living'.

Bauman has formulated a thesis about a shift from 'solid' to a 'liquid' stage of modernity (2003, 2006, 2007) that is also particularly resonant for

a discussion about anxiety. Bauman describes 'liquid modern' as a "society in which the conditions under which its members act change faster than it takes the ways of acting to consolidate into habits and routines" (2013: 1). In liquid modern societies the individual is placed in a process of unending demand for flexibility to negotiate constant change: "In such a society, the sentiments of existential insecurity and scattered fears of diffuse dangers are, inevitably, endemic" (Bauman, 2007: 57).

There are noticeable similarities between observations in social theory and notions of dispersed neoliberal governance outlined in the previous section. These elaborations of modernity describe an uncertain and unpredictable time that may itself produce feelings of anxiety divorced of any pathological origin. Still, it is important to account for the ways in which anxiety has been produced as a bodily experience that is often read as a form of dysfunction.

The language of stress and the introduction of 'mood medicine' are examples of the prominent role of pain metaphors in articulating the subjective experience and impacts of the conditions of late-modernity. The work of endocrinologist Hans Selye in the 1930s was the first to produce a scientific account of 'stress'. Though Selye's work used 'stress' as a way to describe the body's response to external stimuli (1954, 1956), processes of medicalisation shifted the meaning of the term to refer to the external stimuli itself (1977). Stress quickly came to represent circumstances outside of people's control that made them psychologically uneasy (Dowbiggin, 2009). Physicians soon became interested in medicine's ability to manage or alleviate this kind of distress. The emergence of, what has been termed

'mood medicine' developed alongside the introduction of tranquilisers into the pharmaceutical repertoire available in the 1950s. Dubbed 'happy pills' and 'emotional aspirin' the use of tranquilisers gave the impression that medicine could manage and control people's emotional responses to stress (Speaker, 1997).

The related terminology of anxiety became increasingly common after the end of the Second World War, especially as it was applied to returning war veterans. Stress-related anxiety, panic and social phobia became integrated into the diagnostic criteria of a broad range of psychological conditions. By 1980, in the third edition of the DSM, anxiety-related panic and social phobia became stand-alone categories of psychological diagnosis. As the first drugs approved for the treatment of 'panic disorder' (among other psychological diagnosis), alprazolam (marketed as Xanax), and later fluoxetine (marketed as Prozac in the US and Lovan in Australia) were introduced in the 1980s. The introduction of paroxetine (Seroxat and Paxil) for the treatment of 'social phobia' followed in the 1990s (Lexchin, 2001). As is emblematic of medical practice, the increased availability and popularity of these medications fed a process of legitimising the disorders they purported to treat (Shorter & Marshall, 1997).

By the twenty-first century a long history of pathologising stress and anxiety (briefly summarised above) provided socially acceptable ways of understanding and interpreting the physical sensations that accompany emotional uncertainty: "People who feel the aches, pains, and up-and-down emotions of everyday life soon learn that these symptoms have a medical name, which makes them all the more sensitive to their bodily sensations"

(Dowbiggin, 2009: 434). Anxious concern about job insecurity or social awkwardness in late-modernity may also produce the “facial expressions and bodily comportments” (2012: 81) that Bissel described earlier as specific to embodied encounters with physical pain. Crying, clench fists and a thumping heart are not bodily responses specific to physical injury, as social and emotional worry may also elicit a similar response.

Anxiety about the body and forms of emotional distress also extend to other areas of medical intervention and the commercial sphere. Poststructuralist traditions of sociology have even argued that, in contemporary society anxieties about the body are conflated with anxieties about the self. Following Turner’s articulation of a sociology of the body, during the 1980s Featherstone began writing about the modification of the body as a process of inscribing self-hood. Taking consumption as an important frame, Featherstone articulates a context of individualised consumption in which people are encouraged to alter their bodies through consumption, and in doing so stake a claim over who they are:

[T]he tendency within consumer culture is for ascribed bodily qualities to become regarded as plastic – with effort and ‘body work’ individuals are persuaded that they can achieve a certain desired appearance. (Featherstone, 1982: 22)

Poststructuralists note that in consumer discourse consumption is presented as an important political act. The ability to consume is equated with the ability to express oneself.

The ability to fully express oneself and its apparent link to consumption is murkier when applied to the area of social interaction. Medical interventions into social and emotional problems often come up against questions about the way pharmaceuticals can alter selfhood. The controversy that surrounded rising interest in and a backlash against the effects of Prozac during the 1980s provide a good illustration of the vagaries of medicating emotions. Kramer, an American Psychiatrist, authored a book about his experiences with the prescription of Prozac during the 1980s, in which he discusses a client named Tess:

I prescribed [Prozac] for Tess, for entirely conventional reasons – to ameliorate her depression more thoroughly, to return to her ‘premorbid self’... But medications do not always behave as we expect them to. (1994: 7)

Kramer goes on to write that at his next appointment with Tess he observed a significant transformation in her intimate, social and professional relationships:

It makes a psychiatrist uneasy to watch a medicated patient change her circle of friends, her demeanour at work, her relationship to her family... To ameliorate depression is all very well, but it was less clear how psychiatrists were to use a medication that could lend social ease, command, even brilliance... And always there was the question of how

society would be affected by our access to drugs that alter personality in desirable ways. (1994: 12)

Indeed it is significant that Tess reports that her newfound confidence did not last once she ceased use of the drug. After going 8 months without Prozac Tess returned to Kramer saying “she was slipping”:

‘I am not myself.’ But who had she been all those years if not herself? Had medication somehow removed a false self and replaced it with a true one? Might Tess, absent the invention of the modern antidepressant, have lived her whole life... and never been herself. (1994: 19)

Tess’ example illustrates the blurred intersections between broadened understandings of pain relief and the modification of self-hood implied through forms of medication consumption (Wolf, 2002).

Similar debates have surrounded the prescription of methylphenidate (Ritalin) as pharmacotherapy for attention deficit hyperactivity disorder (ADHD). Social theorists have questioned this mode of ‘treating’ ADHD based on people, and mainly children’s ability to ‘fit in’, implying that it may disguise processes of social engineering (Peter Conrad & Potter, 2000; Searight & McLaren, 1998). Use of paroxetine (Seroxat and Paxil) has also been criticised for pathologising ‘shyness’ through the treatment of ‘social phobia’:

[In 2000] SmithKline Beecham received approval to market paroxetine for the treatment of social phobia as defined by the Diagnostic and Statistical Manual of Mental Disorders. This disorder can be distressing and disabling for those who suffer from it, limiting their ability to interact with the outside world. But what we now risk, given the cultural acceptance of (and perhaps preference for) an extrovert norm, is an extension of the definition of social phobia to include shyness: a normal character trait of some people who have no psychiatric disease is turned into an abnormality that requires treatment. (Lexchin, 2001: 1449)

Recent incarnations of the debate about pharmacotherapy for 'erectile dysfunction' are also of note (Kim & Uhl, 2011). Critical theorists have argued that, through its presentation as a biomedical problem, 'erectile dysfunction' becomes disconnected from the social and cultural expectations about masculinity and sexuality that constitute it to be problematic (Johnson & Åsberg, 2012).

In Carl Elliott's influential book *Better Than Well* (2004), the author ponders American society's growing embrace of 'enhancement technologies'. Elliot's work explores confronting ethical questions posed by medical technologies that consciously act to 'enhance' rather than 'cure', often with important consequences on notions of selfhood. Aspects of Elliot's work are inspired by the manufacture of a series of, what were subsequently termed 'lifestyle drugs' during the 1990s (Williams, Gabe, & Davis, 2009). Elliot was particularly sceptical of the prescription of anti-

depressants and stimulants, which he argues contain the capacity to alter the self in socially amenable ways. This is not to deny the suffering that accompanies the conditions for which these medications are prescribed. However to reduce depression, ADHD, social phobia, and erectile dysfunction to biomedical frameworks potentially ignores the ways in which they are socially constructed around ideals of the good life, productive citizenship, extrovert personality and gender norms.

Within late-modern societies an inability to fully express yourself, within established social norms, is increasingly experienced as a form of suffering. Feelings of anxiety are reduced to a pathological classification that locates them in the individual. The way in which pharmacotherapies, like alprazolam, fluoxetine, methylphenidate and paroxetine alter the physiology of the body also has important consequences on people's sense of self. These kinds of approaches to pain do not however simply emerge organically, they have arisen alongside the encroachment of commercial interests into the medical perspective.

The commercialisation of pain

The notion of the body-as-self has also been taken up by commercial interests seeking to capitalise on expanded understandings of pain. Examples of the encroachment of commercial interests in the construction and alleviation of pain have already been alluded to throughout the chapter. Salecl (2004) noted how advanced liberal economies rely on the

reproduction of the anxieties of the modern consumer. Social anxieties about notions of ideal extrovert personality are likely to be feeding the genuine suffering of people who feel alienated by an inability to interact in social settings. The potential to profit from pharmaceutical intervention into the lives of people who do not meet the ideals of modern citizenship requires close scrutiny.

This has notable connections to neoliberal trends in public health. Aspects of public health discourse and policy assume 'White' and middle class ideals about the accessibility and actionability of knowledge about health. One of the consequences of this approach has been the development of a discourse of self-care in aspects of public health rhetoric. Self-care rhetoric is particularly evident in the way contemporary public health has recently embraced digital technology as a way of apparently 'empowering' the patient (Greene & Hibbard, 2012). Lupton has noted that the introduction of "digitalised health information systems, the employment of wireless mobile digital devices and wearable, implanted or inserted biosensors" has encouraged an understanding of 'lay persons' as a "participant' who is actively involved in self-care" (Lupton, 2013: 258). Of course access to such technology often involves significant costs. People's ability to be 'empowered' by these technologies is thus proportional to their socio-economic status.

Technological advancements such as the internet are often presented as more democratic in their ability to 'empower' people to engage in self-care. The Australian Self Medication Industry (ASMI) association is an organisation largely funded by the pharmaceutical industry to advocate for

direct-to-consumer access – or access without medical prescriptions - for a greater number of medications. Originally established in 1974, the ASMI encourages “Better Health Through Responsible Self Care” (2014). Promotional material on ASMI’s website explains a shift in the association’s focus towards ‘self-care’ since 2000 as such:

The take-up of Self Care coincides with a growing interest in personal health and wellbeing, increased access to a wide range of health information... The idea that individuals should take greater responsibility for their health also fits with a growing trend of consumer empowerment. (2014)

The association’s explicit stated purpose is to provide “A roadmap towards greater personal responsibility in managing health”. The website provides a range of information that purports to help consumers make choices about forms of self-care. These kinds of tools are presented as key to the dissemination of health knowledge, and thus allow for the apparent empowerment of the modern health consumer. Commercial interest in allowing consumers to gain direct access to medications is thus disguised in neoliberal rhetoric about self-care.

There are however more subtle examples of the commercial interests involved in a neoliberal push for self-care. The Victorian Government produces a website called the *Better Health Channel* in which research and information about health is disseminated to a broad audience. On the site’s *Wellbeing* page it states “Wellbeing is not just the absence of disease or

illness. It is a complex combination of a person's physical, mental, emotional and social health factors” (State Government of Victoria, 2013). The site also indicates that “researchers investigating happiness” have identified the following factors that influence wellbeing:

Happy intimate relationship with a partner, network of close friends, enjoyable and fulfilling career, enough money, regular exercise, nutritional diet, sufficient sleep, spiritual or religious beliefs, fun hobbies and leisure pursuits, healthy self-esteem, optimistic outlook, realistic and achievable goals, sense of purpose and meaning, a sense of belonging, the ability to adapt to change and living in a fair and democratic society. (State Government of Victoria, 2013)

Information about government services that might deliver these “physical, mental, emotional and social health factors” is however noticeably absent. Instead the website acts largely as a summary of the broad cross-section of information about how to achieve a state of conflated health-happiness – its implicit purpose seems to be a tool to encourage a kind of informed self-discipline. Such websites do little more than provide health information, yet may be presented as apparent alternatives to traditional health and social services.

As part of a broader reconceptualisation of health at an international level medical and health discourse is no longer focused simply on correcting dysfunctional bodies (World Health Organisation, 2014). The State Government of Victoria boasts an entire website dedicated to optimising the

health, and thus happiness of its citizens. Commercial interests have sought to capitalise on this expansion of the parameters of health (and medicine), by seeking to shift the onus of achieving it onto to the lay consumer. Industry groups such as ASMI actively lobby for these kinds of expansions to the parameters of self-care.

There are also significant appropriations of the concepts discussed thus far in the current landscape of direct-to-consumer advertisements for pain medications. A wide range of advertisements for OCT analgesic medications draw on the notion that physical pain inhibits the body, and by extension the self. The physical anguish felt by pain is supplemented by the way it denies or suspends the individual's ability to participate in contemporary society. Within the commercial space, pain is described as an interrupting force on the body, that necessarily cripples or compromises the self. Consumption is thus presented as an important method of remediating, and perhaps even enhancing the body-as-self.

A recent *Panadol* advertisement declares, "Life happens fast. Don't miss out" (2012), while another insists that "There's never a good time to have a headache" (2012). Whether it be on your wedding day, during a workout, or in the middle of an action packed espionage mission, the physical presence of headache pain is represented as an interrupting force that detracts from modern life (2010). One advertisement for *Nurofen* tablets shows a range of people with visible signs of discomfort from headache pain that interrupts their ability to go surfing, take a ballet class, go jogging, take care of the kids, work productively in the office and study in

the library (2010). According to the advertisement, the answer is of course to take two *Nurofen* tablets, which appear brightly lit in the final shot.

In an international television advertisement for *Panadol Extra* a man is shown sitting, leant over, with hands on head, while animated ripples of a threatening shade of red radiate across his body. The narrator says “If tough pain gets in the way try new *Panadol Extra Advanced*” (2012). As the narrator lists the apparent advantages of the new product, the animated ripples of red ‘pain’ dissipate and the male figure is freed to flip off a dive board and energetically cut through the water of a lap pool.

These kinds of advertisements depict a wide range of people engaging in a wide range of social activities. They draw on social anxieties about child rearing, healthy living and productive work, with OTC analgesics presented as the answer to those anxieties. Pain medications are thus presented as drugs that manage the consumer’s ability to participate in leisure activities, child rearing and productive work and/or study – mention of analgesia is rare and only ever peripheral. In advertisements for OTC pain medications pain relief is not simply about alleviating notions of physical discomfort, it also incorporates a significant component of being able to ‘live life to the fullest’. The line between pain relief and self-enhancement becomes blurred and indistinct. Thus the ability to ‘live life to the fullest’ is placed in the hands of the consumer, who simply needs to buy and consume painkillers in order to get on with the day. Taking care of the self is presented as a matter of consumption: the suggestion is that if you consume the right products you will be pain free, live life to fullest and perhaps even enhance the self.

Conclusion

This chapter has explored the medical, social and commercial approaches to pain. It has revealed tensions from within the medical perspective and its implications for the consumption of pain medications. Given that the diagnosis of pain relies almost solely on the patient's perspective, chronic pain in particular delivers a potent challenge to the standard empowerment of the medical expert in the doctor/patient (Baszanger, 1992). If the individual is to determine his/her own health, then what does this mean for traditional understandings of the medical practitioner as the arbiter of health and health practice? Pain medicine and its emphasis on individualised experiences of pain have necessarily expanded the definition of what it is to be *in pain* beyond the parameters of physical discomfort.

As understandings of pain have expanded, the expectation that the body can be free from pain also translates to an expectation that the self can be cured of social anxiety and emotional unrest. In a social context that assumes that the body can be medically controlled, and medication consumers anticipate an increased capacity for medical technologies to alleviate suffering. However, as the specialty of pain medicine has emphasised, pain relief is not always a priority in the medical profession.

Partly informed by physicians concerned about being accused of 'pedalling' a 'drug of abuse', there is no identifiable drive in the medical profession to make pain medications more broadly available. Thus there is a distinct clash between an expanded medical demand to alleviate and control

pain, and an unwillingness to make pain medications freely available for fear of the imagined 'epidemic' that would ensue. The regulation and consumption of painkillers is thus characterised by a tension between the medical promise to alleviate pain and the professional and institutional limitations placed on that promise.

Developments in the sociology of health and illness, and related interests in anthropology and cultural studies, help to conceptualise shifts in and current understandings of the body in pain. No longer simply represented as an indicator of bodily malfunction, the experience of pain invites a series of complex questions about sociality and self-hood. What does it mean to describe emotions and anxieties that may be socially produced under medical frameworks that have pharmaceutical solutions? How are people expected to distinguish between consumption for pain relief and consumption for self-enhancement? These questions remain unanswered in the medical literature.

One response to the tensions in the medical perspective and the expansion of pain to include social and emotional forms of suffering has been a deferral to the neoliberal subject: who is encouraged to find individualised ways to manage the kind of uncertainty and fluidity that characterises late-modernity. Neoliberal discourse and the commercial interests that accompany it have sought to capitalise on these broadened understandings of pain. Contemporary approaches to the body as the location of the self, and which is subject to change through commercial consumption, have important implications on the way pain is labelled, experienced and treated.

In the context outlined here people's individualised appropriation of medical discourse and practice may well provide a compelling alternative to the psycho-pharmacological perspective that has dominated much of the current research literature about non-medical consumption. The next part of the thesis will address some of the questions raised here by directly engaging the perspectives of those who themselves use painkillers non-medically.

Part Two – Lived experience: Introduction

The second part of this thesis explores the lived experience of non-medical consumption. Whereas Part One addressed official accounts found in historical, policy and research documents, Part Two focuses on the accounts of those who themselves use pain medications. User perspectives were collected through qualitative semi-structured interviews and are contrasted in important ways to the official discourses explored thus far. Historical analysis in Part One revealed how medical and political knowledge have produced an unstable, though prevalent cultural distinction between legal and illegal opiates. Research accounts are dominated by references to non-adherence to medical authority and substance ‘abuse’. This has occurred alongside broadened understandings of pain in medical, social and commercial fields. In each case official discourses assume that non-medical consumption involves criminal and medical pathology.

What is absent from this literature is qualitative accounts that are reflective of genuine engagement with the perspectives of people who use painkillers non-medically. Part Two of this thesis addresses these empirical shortcomings by engaging a spectrum of user perspectives. The project involved the participation of PWID, however the majority of the sample was not derived from this group. In taking a broader approach to sampling a range of non-medical practises not limited to IDU was revealed. These

practices were mostly distanced from the networks of criminality articulated in much of the current literature.

Debates about the importance of user perspectives have already been waged in drug research more broadly, and research communities have reacted accordingly (Nichter et al., 2004). Though still dominated by quantitative methods, there is now also an abundance of qualitative research that details the complexities of drug consumption, in a range of contemporary drug cultures (Amos et al., 2004; Rhodes et al., 2007; Sherman et al., 2002). However, research communities have mostly ignored this debate in the case of non-medical use. Part Two of this thesis begins an important qualitative exploration of non-medical practices as well as a critical assessment of their meanings. Conversations with people who use pharmaceuticals non-medically reveal both the range of practices that exist and the kinds of narratives that are produced around them.

Data collection

The key empirical component of this project involved talking to people who engage in non-medical consumption, in the form of qualitative semi-structured interview. Interviews sought to answer core questions. Who are the people that are consuming painkillers non-medically? How do they think and talk about what they are doing? Participants were sourced from health care facilities (n=2), tertiary education institutions (n=2), the internet (n=17) and personal approaches (n=4). This took the form of flyers that

were also adapted to the format of three websites: www.airtasker.com, www.facebook.com and www.gumtree.com. The project targeted a variety of people who use painkillers that ranged from occasional, to regular/recreational and dependent. 27 interviews were conducted with 25 user participants (2 participants were interviewed twice).

Once potential participants were identified the researcher met with them to explain the scope of the project. This involved a discussion of the kinds of information being sought as well as an explanation about the critical/social research perspective being taken. Participants were informed that the project would not be taking a survey format and that they would be asked to share stories from their lives in as much detail as they could recall. It was also explained to participants that this experiential knowledge was an important element of social research, as it provides a contrast to medical and public health approaches to the issue. It was made clear that the project would thus involve a contrasting of their stories and language with dominant understandings of non-medical consumption. Ample opportunity was also provided for participants to ask questions about the project and its approach.

User narratives were gathered through semi-structured qualitative interviews, organised around guiding questions. Participants were asked to recall initial and 'stand out' experiences with painkillers. This involved questions such as: Do you remember the first time you used a painkiller? Tell me about that experience; Have you had any experiences with painkillers that stand out to you? Tell me about them. Participants were then prompted for more detail of key areas related to personal experiences

of use and opinions related to health and social practice. This included prompts such as: You mentioned that taking a painkiller was part of your 'medical kit' when you go out. Tell me more about that; You mentioned that you used to take painkillers mainly when your alone. Why is that? These prompts also allowed for broader discussion of participant perceptions of painkillers, their health concerns and legal status.

This approach provided the flexibility for the interviewee to contribute to the direction and content of the resulting data (Silverman, 2013: 204) while also allowing for information that responded to dominant concerns about painkiller use. The flexibility of semi-structured interviews was important for the collection of data because it allowed for the development of narratives that could sufficiently reflect the social and political context in which painkillers are consumed. All of the questions were open-ended and sought to elicit narrative answers. This provided participants with ample opportunity to follow lines of thought that were not strictly directed by the researcher (Wengraf, 2001). Follow up questions, requests for more detail and reflection on the relevance to the research were developed informally throughout the interview session so as to more appropriately resemble the spontaneity of everyday conversation (Silverman, 2013: 204).

Use of a conversational style is in deliberate response to the notion that the interview is a 'social event' (Hammersley & Atkinson, 2007: 126) implicated in the constitutive production of the object of study (Law, 2004). The specific wording of the questions thus changed with each interviewee, based variously on the language of the participant and the rapport developed with each. Particular effort was made to adopt the language of

the participants to keep the interview session conversational (Rubin & Rubin, 2012). This style ensured that participants were not made to feel like they were being interrogated by an authority figure.

Interviews were also conducted in casual environments. Two interviews took place in a local hotel and one in a public park, however most of the interviews took place in study rooms at various public libraries and UWS campuses. The more sensitive the information to be shared was likely to be, the more private a venue was sought. One interview was for instance conducted in the counselling room at Sydney MSIC.

Interviews were audio recorded. Once the interview had been completed a copy of the audio file was kept on a private server assigned to the researcher at UWS. The researcher then transcribed the audio files verbatim and the resulting transcripts were analysis based on thematic content. The names and other identifying details of participants were removed during the transcription process. Once completed transcripts were kept in a locked draw at the Institute for Culture and Society, UWS, for which the researcher was the only one who had access.

Research approach

The sample of this study includes a mixed group of people that derive from a diverse range of social and socioeconomic backgrounds. The diversity of the sample was spread across a range of demographic factors as well as the type and frequency of painkiller consumption. Majority of the sample was under

the age of 40, with the mean age of the sample at 31. The gender spread was basically even, with 13 male participants and 12 female participants. Approximately half of the sample had completed High School to year 12 and a smaller group (n=6) had undertaken tertiary education. The remainder of the sample had not completed high school (though 3 had completed the HSC at TAFE).

With regards to type and frequency of use, participants responded to advertisements targeting or self-identified with three broad categories; aberrant/occasional use (n=8), regular/recreational use (n=9), and dependent use (n=8). It is important to note here that there were no diagnostic criteria ascribed to any category. Instead participants were given a descriptive explanation of what each category may represent. Aberrant/occasional was described as the infrequent non-medical use of painkillers; regular/recreational use was described as a consistent pattern of non-medical use (though some participants took this to mean use of painkillers as part of other forms of recreational consumption); dependent use of painkillers was described as constant use for which you feel you are reliant on. It is also important to note that participants often discussed a blurred boundary between these categories, and as a result they were not used to guide the analysis processes.

These demographic and drug use practice groups were specifically targeted to both explore the qualitative features of the current set of practices being explore in the research and to expand out the kinds of practices being observed. This approach allowed painkiller consumption and the practices that surrounded it to be placed in a broader context than

only public health or criminal justice concerns. Analysis of the data acknowledges that participants have different relationships with painkillers in different context, making their effects and ways of use contextually contingent. One key feature of moving beyond dominant (medical) understanding opiate of consumption is a broader interpretation of the term dependence. The notion of being reliant of painkillers to maintain economic sustainability, emotional attachments or social relationships is used in conjunction with medical notions of tolerance and dependence. Forms of economic, emotional and social dependence are taken to be intimately related, rather than entire separate to physical dependence on opiates.

Given that a variety of user perspectives form the empirical component of the project, it is also important to reflect on what the data collected actually *is*. The interview data derived from conversations with participants should not be thought of as definitive descriptive measures of non-medical consumption. Neither should they be thought of as part of a holistically ethnographic description of how people practice the non-medical (ab)use of painkillers. The project acknowledges that contradiction and contestation make up people's experiences of non-medical consumption. This requires abandoning the notion that descriptions of it can be neatly described as either 'accurate' or not. Silverman has noted that "we need not hear interview responses simply as true or false *reports* on reality. Instead, we can treat such responses as *displays* of perspectives and moral forms" (1985: 157).

Participants were asked to respond to different public and professional concerns about non-medical consumption, and to describe how

these may have informed their own life experiences. The significance of narrative production is well established in cultural studies: “People make sense of their experiences, claim identities, interact with each other, and participate in cultural conversations through storytelling” (Langellier & Peterson, 2011: 1). The content of these interviews is used to analyse the social and political arrangements that participants deem to be part of the contexts in which they consume painkillers. The way in which participants chose to describe those contexts, the language and phrasing they use, is also analysed for the way it frames non-medical consumption within particular discourses.

The interview data collected as part of this project begins an important qualitative framing of non-medical consumption absent from the current literature. Qualitative assessment of interview data was framed by a range of social theory about consumption and drug use in contemporary society.

Chapter Five – Chilling out

Recreational pleasure is a key motivation for drug use, whether it be with licit products like alcohol and tobacco, or illicit substances such as heroin and ecstasy (Holt & Treloar, 2008). The 'release' provided by an inebriated or altered state of mind is a popular way to break from the grind of everyday life. While this has been the case for some time in 'Western' or developed nations, it is important to note significant demographic changes in the consumption of drugs during the last sixty years. During the 1960s in particular young people in the developed world took to recreational substances in greater numbers (Blackman, 1996). Since then social researchers have focused significant attention on the connection between youth and drug use. Contributions from cultural studies (Sulkunen, 2002), and subdisciplines such as the sociology of youth (Shildrick, 2002) have explored the appeal of recreational drugs for young people to 'escape'.

While the study did not solely focus on young people, recruitment methods did yield a relatively young sample, the majority of which were under the age of 40. This chapter focuses specifically on the experiences of young people because of similarities in the way this group discussed non-medical consumption. The young people in this study spoke about painkillers as being used for recreation or as part of practices of recreational illicit drug use. For the young people who participated in this study 'chilling out' was a key reason for their use of recreational and other drugs. This chapter discusses how recreational and analgesic drugs are used to 'escape' from physical and emotional discomfort. It explores the way young people

incorporate painkillers into forms of recreational drug use. For some participants this meant using painkillers instead of illicit drugs, while for others painkillers are used in various combinations with illicit drugs.

The chapter starts by discussing interview data about the use of painkillers for 'a numb feeling', in order to avoid general discomfort and emotional worry. The use of pain medications as an intoxicant, or to 'get off your face' is also explored. The chapter then moves to discuss painkiller use when 'coming down' from and managing the 'scary' effects of illicit drug use. Finally the chapter addresses the normalisation of illicit drug use and the way painkillers have come to form part of a similar process for many of the young people who participated in this study.

Young people who use drugs

This chapter provides an empirical discussion about a group of young people (aged 18-30) who use drugs for recreation, and the different roles that painkillers play in this process. The non-medical consumption being described in this chapter includes the use of OTC as well as prescription medications. Some of the data derives from interviews with people over the age of 30, but for whom experiences of painkiller and other drug use occurred largely while aged between 18-30. The group of seven participants discussed in this chapter represent a set of young people who are familiar with recreational and other forms of drug use. The participants were well educated with all participants having completed high school. Four hold an

undergraduate university degree, and one is enrolled in postgraduate study. They demonstrate an awareness of the properties of the drugs they consume and the effects this might have on their body. For some this was acquired through formal education (one participant was for instance a chemistry graduate), and for others this knowledge was acquired through social osmosis or personal experience.

For many of those interviewed, painkillers were the drug of choice to provide intoxication, whereas for others painkillers simply mediated the 'high' of illicit drug use, or managed the health consequences of drug use generally. A significant element of the way participants speak about recreational drug use involves the concurrent use of illicit drugs and pain medications: what is referred to as 'polydrug' use. These forms of drug use inform the discussions that make up this chapter.

A numb feeling

One of the key motivations for using painkillers non-medically among the young people who took part in this study was for the 'numb feeling' they provided. Participants spoke about the use of painkillers to manage forms of physical and emotional discomfort that was 'numbed' through the effects of the drug. This involved the use of painkillers for mild physical discomfort that did not equate to acute pain, or the use of higher dose or prescription medication that exceeded the relief required for the level of discomfort being experienced. This section will focus in particular on two young men

named 'Sean' and 'Collin' who play on the same inner-city rugby league team together.

'Sean' was a quick-witted 25-year-old who lives in an inner-city suburb of Sydney. When describing the reasons why he used pain medications, Sean says that they make him feel "*numb in all the right ways*" ('Sean' - Interview, March 9, 2012). He described a range of contexts in which he uses painkillers to achieve this 'numb feeling', some of which include after playing rugby league, when socialising, as well as after a break up with his girlfriend. The 'rough' atmosphere that constitutes the physicality of the game of rugby league is one example of the kind of reason why Sean might use an OTC medication like Panadol: "*I always have them after football games*". Sean explained that physical discomfort after rugby games did not always warrant the use of pain medication, but that he often used them to be more 'comfortable' as he goes out to socialise after a game: "*And you're all so tough and sore and you wanna go out drinking afterwards*".

Sean also spoke about the use of painkillers for forms of physical discomfort unrelated to sport. He talked about occupying a state of general discomfort: "*Well it's the type of little aches and pains you don't realise you're carrying with you. Like you might have a stiff shoulder. I got a sore back... But just those little cricks that your body has*". When Sean felt these kinds of everyday discomforts, he often takes Panadol as well as other prescription medication when available: "*It just kind of takes them away, and as a result you just relax as well. Where you might be holding yourself in a certain way, keep[ing] your shoulders straight, you can just kind of sink into it*". This

physical 'numb' also provided an emotional relief for Sean, who goes on to say that after taking a painkiller "you're just like 'ah it's all ok now'".

The use of painkillers was not however Sean's only response to general discomfort. Sean explains that he tended only to use painkillers when they are available or when friends are taking them: "*Most of the time it's – 'social' is the wrong word. I see someone else taking something and I'm like 'actually yeah I could probably go for some of that'*". He goes on to provide an example from two years earlier, in which he was returning from a trip away with his then girlfriend:

We'd just been on a really long drive. It was about eight hours. And we got out of the car and she was complaining about a sore neck from driving and sitting.

Sean recalled that, after his girlfriend decided to take a painkiller:

I just said "actually, now you mention it I've got a sore back too". Why not. Like I didn't really need one. And we only had Panadeine Forte, and we said, yeah we'll have that, and if there's a little bit of a buzz to it why not. I think we had a glass of wine as well. We got very relaxed.

Sean presented a blurry line between painkiller use to alleviate discomfort and to experience pleasurable relaxation. Mention of the 'buzz' of the painkiller and its use in combination with alcohol both imply a recreational component to relief from physical discomfort.

One final example of Sean's use for a 'numb feeling' came after he broke up with his long-term girlfriend. Sean used painkillers and other pharmaceuticals to help numb himself from some of the emotional difficulty of the loss:

I just broke up with my long term partner and I just couldn't sleep. It's like a combination of guilt and sadness. And [the painkiller] wouldn't really affect the sadness that much, but it would help me alleviate the guilt and go to sleep. So I'd just take a temazepam or a Nurofen when you wake up at two in the morning.

For Sean painkillers did not alleviate the emotion itself, but they did provide a physical sensation that allowed him to cope better with the emotional circumstances. Feeling "numb" is described as particularly helpful when trying to get back to sleep or get on with the day: *"if the morning was particularly grim, you just take it, just [to] help the day"*. For Sean the 'numb' of the painkiller helped him to cope with what he regarded to be the physical manifestations of his emotions:

There's definitely a physical component [to strong emotions]. It's just a constant dull pain... The expression heavy heart also comes from that same experience. Because you feel like you're carrying a heavy necklace inside or something. And it's weighing you down.

Sean goes on to say that without the painkiller “*you’re still aware of all of the crap*”, but when you take a painkiller “*your psyche has a nice warm blanket around it*”.

‘Collin’ is an easy-going 25-year-old who also spoke about the use of painkillers to deal with a break up. While backpacking across South East Asia, his girlfriend broke off their relationship via a private message service on the social networking website *Facebook*:

It was after a break-up with a girl I had been seeing for two years. Overseas at the time, and so she broke up with me while I was overseas via email, actually via Facebook. It was pretty heart-wrenching, and there was no sense of closure about it. (‘Collin’ – Interview, 9 March 2012)

The lack of closure played on Collin’s mind for much of the trip, not being able to properly respond until he returned home:

So I was left wondering about it for a while. So every morning I’d wake up and there was that couple of seconds before you wake up and you’re just normal. Then you remember. And you’re instantly upset again.

During the trip Collin found himself regularly taking benzodiazepines and OTC pain medication: “*I guess maybe subconsciously there was a part of me saying take it because it will make you not upset anymore... You know [a little voice] says take a pill, drink, have some weed*”. He described the physical

'numb' provided by the painkiller as particularly useful for avoiding thinking about the break up before sleep. Collin explained that, on this trip he used painkillers "*as a sedative to get to sleep, 'cause you are kind of kept awake by thinking about it too much*".

The use of painkillers to manage physical/emotional discomfort is a recurring theme among interviewees. Indeed most of the young people who participated discussed some element of the alleviation of intertwined physical and emotional unrest. Discussion about a 'numb feeling' was however the most explicit reference to forms of drug use that attempt to relieve discomfort in the body. For participants who placed a more prominent focus on pleasure, the notion of 'escape' from life circumstances became a significant point of discussion. Use of painkillers for the explicit purpose of intoxication (or to 'get off your face') forms the focus of the next section.

Getting off your face

At the time of interview 'Heidi' was a 33-year-old married mother of two boys under the age of 10. She lives in the outer suburbs of Melbourne. Most of Heidi's recreational use of painkillers occurred alongside previous injuries or medical conditions for which she was prescribed strong analgesics. Heidi explains that the recommended dose provided by her prescribing physician was often unsatisfactory to cover her pain, and so she began to exceed the dose:

[about five years ago] *I'd just been in hospital with food poisoning. While I was in emergency they'd given me two Panadeine Forte's. While it didn't really help, when I was discharged from the hospital they gave me a prescription for another packet of 50 Panadeine Fortes. So when I got home and I was still having pain I took two, and it wasn't doing much so I took another two and felt that I was a little bit high".*

Soon Heidi recognised that she enjoyed the pleasurable 'high' she received when using analgesic medications over the prescribed dose, and began doing this when the medications became available:

Heidi: I've got a lot problems with my wisdom teeth. I was given Tramadol for that. So I took the prescribed dose, what I was meant to have, and I thought it was fun so I took more.

Researcher: And why did you take more?

Heidi: Because I wanted to get off my face. High. Because it's fun.

She goes on to explain that this was often a result of boredom. When she was unwell or in pain her partner or parents would take care of her children, which left her with less to do: "*while I was having some pain at the time, I took more than I should have. I just thought I'm taking one for my teeth and I thought 'well I might as well have a few more just to have fun'. Just something to do".*

Heidi has also used other drugs recreationally for similar reasons: *“I’ve always like[d] getting drunk or high or something. I guess it’s probably just an escape for a few hours. Just to feel physically and mentally different. It’s just a good little break”*. Prescription analgesics are described as a way of providing a unique kind of intoxication for Heidi, one different from what she might normally experience: *“I usually drink a lot, [but] I don’t smoke dope anymore. [I used Tramadol because] I just felt like feeling different. Different to usual”*. Painkillers are also described as different in social terms:

It’s more of a personal thing. If I was to smoke dope I would do that in front of people and share it, but when I take painkillers it’s just a personal thing for me... You can happily go to the bar and buy everyone a drink, but you can’t pull out a packet of pills and give everyone a pill. It’s a lot different.

She goes on to say that, when using painkillers recreationally, *“I wouldn’t be sharing it with anyone. I’d rather just keep that little high to myself. And in myself. I just don’t see it as a sharing, social type thing to do”*.

Heidi did however clarify that *“it depends on who I was with”*, explaining that she had used painkillers recreationally with a friend who has *“really bad endometriosis”* (a condition which affects the tissue surrounding the lining of the womb). She recalled that *“I was at this friend’s house, we we’re drinking beers. She had a bunch of Panadeine Extra. We crushed up the pills and I showed her how to extract the codeine and we both had that”*.

Having learnt how to filter the codeine out of pharmaceutical products in her teens, Heidi explains the process:

You just crush up the pills then mix it all together in water. And then filter it through a stocking or a tea-towel or something like that, and everything that goes through to the bottom is codeine and the water and the paracetamol stays on top.

For Heidi, painkillers provided a different kind of 'high', one that broke from the norm and was thus desirable as a form of 'escape'. Her use of painkillers in this way is however largely limited to when they have been made available through a legitimate prescription or when a friend decides to share.

Another participant named 'Samantha' also used painkillers for intoxication. Samantha is a 23-year-old Australian with English heritage, who lives in a well-to-do suburb on Sydney's north shore. At the time of interview she had recently entered a PhD program at the university where she completed undergraduate and honours study. Samantha was first introduced to morphine after a surgical procedure she underwent several years earlier:

I had a PCA (patient-controlled analgesia) monitor after the operation for 12 hours. And so I was hitting it really hard. It was safe because it was in a controlled environment 'cause I was in the hospital. And that kind of gave me a taste for it. ('Samantha' – Interview, July 4, 2012)

Once she was released from the hospital Samantha explained that she kept “*chasing the feeling*” she had while using morphine.

After leaving hospital Samantha started to use Panadeine Forte, a high dose paracetamol and codeine combination that requires a prescription. Part of the reason why Samantha started to use Panadeine Forte was to help cope with an eating disorder she developed around the same time: “*I would binge and then purge. If I couldn’t make myself vomit then I’d want to have pain medication to knock myself out so that I could sleep for ages*”. Not only did the prescription analgesic provide a euphoric feeling, it also acted as a sedative that Samantha used to manage the effects of binge eating. She explained that going to sleep right after eating was desirable because “*when I woke up it would feel like my body had digested it*”.

Samantha also explained that the ‘high’ she experienced on Panadeine Forte was particularly good, especially when compared to forms of illicit intoxication. Previous experiences with illicit drugs have left the impression that they can be, what she described as a ‘dirt high’, and pharmaceutical opioids are ‘clean’ in comparison. Previous experiences with ecstasy and methamphetamine have left a negative impression of illicit drugs: “*You can have pills or meth, it’s really dirty. And you can kind of feel that it’s really dirty. I swear that before when I used to take ridiculous amounts of pills I felt my brain shaking my skull*”. By comparison, pharmaceutical opioids are described as ideally consistent:

But when you have something that is opiate based, especially if it's prescription medication you know that it's clean... I've had pretty much every drug you can have and it's the ultimate drug that you can have. It's just complete bliss. It's amazing. It's just one constant feeling the whole time. And then it just wears off.

Both the sedative and euphoric qualities of the Panadeine Forte kept Samantha using the medication for several months after leaving the hospital.

After approximately four months of this kind of sedative/recreational use Samantha discovered a stock of Panadeine Forte that her mother had gathered from left over family prescriptions: *"I just found out where it was and there was just this massive stock there. And so for about a month I just ate my way through all of it"*. Her use of the medication escalated, ultimately culminating in a frightening overdose experience in which she also used the prescription medication Seroquel, which had also been prescribed to her as part of her post-operative treatment:

In January of this year I had 300 milligrams probably at 8pm, then wasn't feeling it. Then had another 300 milligrams. You normally only have to wait half an hour to get the effect, but I wasn't getting the effect, so I had another 300 milligrams. So I had three times my dose, I had pretty much a thousand milligrams of Seroquel. The immediate release, not the standard release. And then I felt myself OD'ing. 'Cause I've OD'ed before, so I knew how it felt. And I went into my mum. I said "I've just

overdosed". My mum gave me heaps of salt water, trying to make me vomit.

After a close call overdose experience Samantha decided she needed to stop using them: *"mum found out that I'd been going through this stash. And there wasn't any more left and she was really really upset. And then I kind of had to stop 'cause I knew that I would die because of my liver"*.

On reflecting about her time using painkillers Samantha is critical of dominant medical and popular discourses that implicate emotional instability as a reason for recreational use. She explains:

Samantha: Well I suppose they [doctors] would say that you use because you had emotional issues.

Researcher: They might say that, but does that connect for you?

Samantha: They might say that. But honestly... I just use because I like the feeling and that is a really selfish thing to do. I don't think it's any deeper than that... I'm just seeking that feeling.

Samantha also dismisses the role her eating disorder, and associated emotions, may have played in her use of Panadeine Forte:

honestly I would love to be able to say “I use because I had childhood abuse” or “shitty self-esteem [about my body]”. Which is what doctors tell me, but I honestly think that my use is just really really superficial.

In reflecting about why Samantha used painkillers for intoxication, she said that it is “*just something to do*”.

Escaping from boredom is a key feature of AOD (Boys, Marsden, & Strang, 2001) and sociological (Workman, 2009) literature. Much of this literature however focuses on populations of young men. The ‘deviant’ status of illicit drug use is thought to make the practice more appealing to groups of young men who enjoy taking risks (Collison, 1996). Young men who use drugs are often described in the literature as performing a masculine bravado that revels in risk-taking. Heidi and Samantha demonstrate that this kind of drug use is not simply a masculine pursuit. Research in the AOD field has demonstrated that, while (male) intimate sexual partners play an important role in initiation of injecting drug use among women, women also assume a determining role in the path to escalating and/or injecting drug use (Bryant & Treloar, 2007).

The gendered elements of Heidi and Samantha’s experience are worth noting. Heidi’s life is usually bound up in child rearing and its associated responsibilities. However, when she becomes ill and care for the children falls to her partner, Heidi is left with “*nothing to do*”: this is when she uses painkillers and other drugs. Samantha’s use of painkillers to manage elements of an eating disorder also involves a gendered component. Here, body image and boredom collide as Samantha uses painkillers to “*knock*

myself out” after binge eating because *“it makes me feel better”*. The next sections explore the way participants use painkillers to help slow the effects of or come down from illicit drugs.

Changing it up

So far this chapter has explored the use of pain medications as an intoxicant. It has described how a group of young people use painkillers for some form of intoxication, and often within a repertoire of other drugs. This section and the one that follows focus specifically on participants who use illicit drugs to ‘get high’, but also take painkillers to ‘mellow’ or reduce intoxication. This includes the use of prescription painkillers to produce a ‘different’ high, as well as use to help ‘come down’ from illicit drugs – both of which are practices that a participant named ‘Tom’ engaged in.

Tom is a 30-year-old back-packer who has been travelling across Australia for the past 5 years. He spoke about taking high dose analgesics that require a prescription in Australia at various stages during periods (several days) of cocaine and MDMA consumption. Tom said that he would sometimes crush up prescription painkillers and combine them with cocaine for a *“gentler”* high. This was mainly after a long stretch of cocaine use where *“I wanted to keep it going, but I know I could probably do with a bit of a more mellow buzz”*. In order to avoid reduced excitement, or risk *“peaking too early”*, Tom intervenes by combining painkillers with cocaine to *“change it up”*.

Tom also spoke about the use of painkillers towards the end of a “*big night*” on MDMA. He explains that oral painkiller use would help “*wind down the party*” and allow him to go to sleep:

you’d take them just after a night, if you wanted to go to sleep. Or maybe you’ve taken so much that you need to chill-out or something afterwards, so you stop taking the cocaine or e and then you take maybe a diazepam or a tramadol just to chill out and relax.

Use of prescription medication to “*chill out and relax*” towards the end of the night also extended to the morning after in some instances:

I remember one particular time... everyone went out that night and the next morning the sun was coming up and the party was still going. We decided to take the party outside and we were still drinking out there. And a friend, she was a nurse in an old folks home, so she had access to Valium and Oxy and stuff. And we had a few of them going round and I can remember just lying in the grass just watching a couple of swallows flying about. Just easing out of the party mode.

Descriptions of painkiller use to mellow or wind down illicit intoxication was also discussed by other young people interviewed for this study.

Collin, who was introduced earlier, also used painkillers to manage “*freak outs*” (mild psychosis) when using “*magic mushrooms*” (psilocybin mushrooms). Where Tom was getting bored of the high, Collin describes

feeling anxious because of the effects of the drug, and thus used painkillers to make sure he could enjoy the experience. Collin recalled using hallucinogenic mushrooms on a road trip with friends to a national park on the outskirts of south-west Sydney:

It came on very strongly. Having had the experience before, I knew that it was going to be ok, but you can't get rid of the anxiety that comes with it - just because it's a natural chemical response to hallucinogens.

Having had some medication left over from his trip to South-East Asia, Collin brought an assortment of analgesics and anxiolytics (antianxiety agents) with him just in case. Collin explained:

And so the meds, that we'd actually bought in Laos, we took with us that day as a backup, if we felt anxious. And I did, so I took it, and it transformed me. Because I wasn't having much fun 'cause I was a bit too freaked out. And then ten minutes later I was just down with it.

This was something Collin recommended for use with all kinds of hallucinogens, remarking “*it works well in conjunction with acid if you get anxiety with it at all. It takes the scariness out of the experience*”. Collin recalled previous experiences where he did not have access to any medication to regulate his use of hallucinogens and emphasised his inability to enjoy those experience. Bringing the “*meds*” leftover from Laos meant “*it just makes the whole experiences more pleasant*”.

Tom and Collin used painkillers as a way to improve their experiences on illicit drugs. Painkillers provided a pharmacological complement to the drugs they consumed that “*changes up the high*” (Tom). These young men describe painkillers as “*safe*” (Collin) and “*trustworthy*” (Tom), and thus as ideal to help alter or adjust their experience when using recreational drugs. The idea that painkillers are relatively benign and largely reliable is a sentiment echoed by many of the participants discussed thus far, and also extends to the way participants spoke about the use of painkillers towards the end of the night.

Coming down

This section explores the use of painkillers when trying to come down off of recreational drugs. It discusses the experiences of two young women named ‘Bianca’ and ‘Jane’, both of whom use psychoactive drugs intermittently on weekends. Bianca is a 27-year-old participant who spoke about using painkillers after a “*big night*” when using illicit drugs. She is an administrative officer at a large retail supply company, and has suffered from a painful condition called Familial Mediterranean fever since her mid-teens. The condition flares up unexpectedly and is often difficult to predict. This has meant that Bianca has been prescribed a wide range of pain medications, and is very familiar with the effects these drugs have on her body. While her use of prescription painkillers related mostly to this

condition, she did also speak about the use of painkillers in the context of recreational drug use.

Bianca spoke in particular about taking painkillers such as Nurofen when trying to 'come down' from "ecstasy" (or MDMA). While Bianca's preference was to use sleeping pills, when none are available she takes leftover painkillers to try and get some sleep after a 'big night out': *"If I had no sleepers [sleeping pills] left and I needed to like calm myself down or relax to sleep. Even just Nurofen or I get Tramal"* ('Bianca' - Interview, April 16, 2012). Much of the time her use of amphetamines occurred in conjunction with a night out in clubs and bars in night-time entertainment districts in Sydney. Bianca recalled that she uses painkillers *"after taking illicit drugs or something, when we're out dancing and whatever all night, 'cause it's got the calming effect so it helps to put you to sleep"*. The analgesic effect is described as useful in a kind of renormalisation of a bodily state that will allow sleep: *"[painkillers] just have a kind of analgesic effect on my body. So it does help when you're coming down"*. Though Bianca recognised that painkillers are not the ideal mechanism to reverse the effects of amphetamines and that she was not taking them under ideal circumstances, they did provide *"the closest thing"* to a solution for her.

A participant named Jane also spoke about the use of painkillers in a similar way to Bianca. Jane is a soft-spoken 26-year-old who lives in the Eastern Suburbs of Sydney. She described a confident knowledge of how painkillers work and what they can be used for: *"I've definitely given pain medication to friends when they were in pain... and told them about like how pain medication works. Like a lot of people are really ignorant about different*

things" ('Jane' - Interview, 9 March 2012). She would also often educate friends on the "active property in different stuff" informing them that "they can't combine these things, but that they can combine these things". An example of Jane sharing her acquired wisdom with a friend is below:

Like recently a friend of mine had really bad tooth pain, she had exposed nerves, and didn't have the money to go to the dentist immediately... So I was helping [her] juggle... Nurofen [and] Panadeine. I was like 'You have to eat when you have Nurofen!' She didn't even know that.

This confidence in knowledge of the effects of analgesic medications informed the way Jane used them with illicit drugs. Jane explains:

I've mainly used codeine combined with paracetamol or Nurofen, over-the-counter, in order to get to sleep. When I've had a big night or - yeah, just to get to sleep, or just calm myself down... Mainly it would be using amphetamines, so it would be dexamphetamines or MDMA. Anything that was in my system that was keeping me awake. So if I wanted to counter that.

She goes on to describe one particular time she used painkillers after taking MDMA a few months earlier:

So I think I remember my ex-partner and I were at his house and we'd had, like sort of a psychedelic. And after quite a few hours of being high

we wanted to go to sleep. Some of the effects of what we'd taken weren't very nice... we were in a safe place, with each other, but we were ready to go to sleep and finish the night.

Jane was however clear that *"I don't use them all the time"*, but prefers having them with her *"in case something goes wrong"*. She explained that *"I can remember more like just being prepared. It's like part of my medical kit if anything goes wrong, that's there if I need it, or if anyone I know needs it"*.

Jane recalled that her use of painkillers in combination with recreational drugs is one way she managed the illicit context of her consumption. This is informed by a reluctance to rely on the medical profession when engaging in illicit drug use: *"I don't want to have to go to an emergency ward or whatever and tell them what I've taken. And it's never really that bad, so I don't really need to anyway"*. In order to avoid the assumed stigma of an encounter with a medical practitioner Jane takes a *"just in case"* approach by bringing painkillers along when she knows she (or her friends) will be taking illicit drugs.

The practices described by participants in this and the previous section indicates significant overlap between the pursuit of pleasure and safety. Participant descriptions about the pleasurable aspects of illicit intoxication are tied closely to its perceived safety. Tom used painkillers concurrently with other illicit drugs to slow the pace of long periods of cocaine use. Collin used analgesics, among other medications, to reduce the anxiety producing elements of hallucinogens. Bianca's use of sleeping pills and painkillers make sure she can get to sleep after a big night. Jane

prepares for possible risks to her and her friends' wellbeing by making sure that painkillers are available as a precaution. These kinds of practices are produced, at least in part, by the criminalised context of illicit drug use. Participants sought to avoid the moralising gaze of medical practitioners and the aggressive and punitive approach of police officers. Participants take up the use of painkillers to compensate for the lack of provision of health and safety usually deemed to be the responsibility of medical and policing services.

For many of the young people discussed here, painkillers are thus associated with limiting or retreating from conviviality and sociability. In the context of recreational consumption, painkillers are associated with the private rather than the public sphere. The 'privacy' of painkillers - juxtaposed with the sociality of recreational drugs - thus involves a politics of care. Painkillers are used to numb, come down, 'make safe' and allow sleep. The 'safety' analgesics provide involves an element of soothing or reassurance. The 'soothing' status of painkillers, as drugs used in private or to comfort, means they are an easy complement to normalised practices of recreational consumption.

The normalisation of drug use

Analgesics are an everyday resource that participants can relatively easily incorporate into their drug taking practice in order to enhance it, as well as make it safer. The examples presented thus far form an interesting and

important departure from the majority of current epidemiological literature about non-medical consumption, which focuses on the intravenous use of pain medications. For the group of participants discussed in this chapter, intravenous use and 'addiction' does not feature as a concern – if mentioned at all discussion of injecting or 'addictive' consumption was only discussed in passing references. Instead, recreational and non-medical drug use forms a relatively mundane and unproblematic element of the lives of the majority of the young people who participated in this study. In saying so research and scholarship about the normalisation of drug use may be useful to help explain aspects of the recreational and analgesic drug consumption of the young people in this project.

Research about the normalisation of drug use is informed by traditions of critical drugs scholarship. In the early 1960s and '70s contributions from the sociology of deviance and subcultural theory explored conceptualisations of drug use as 'normal'. Becker (1963) and Young (1971) both rejected conventional understandings of the 'drug user' as morally and socially 'deviant', preferring instead to produce comparisons between illicit drug use and aspects of 'normal' consumption in society (Measham & Shiner, 2009). The continued resonance of the normalisation thesis in contemporary research can largely be attributed to convincing empirical evidence that indicates that the proportion of young people who use or come in contact with illicit drugs has steadily increased since the 1960s (Redonnet et al., 2012; Shildrick, 2002).

The work of British researcher Howard Parker has been particularly influential in developing current debates about the normalisation of illicit

drug use among young people. Parker developed a thesis about the changing role of recreational drug use in British youth culture since the 1960s. As part of this thesis, Parker argues that drug use is no longer embedded in rebellious subcultures, and that it now forms a 'normal' part of young culture and practice (1998). In a longitudinal study with 465 young adults (aged 18-29) Parker and colleagues assessed: "availability/access; drug trying rates; usage rates; accommodating attitudes to 'sensible' recreational drug use especially by non users; and degree of cultural accommodation of illegal drug use" (1998: 941). The research showed that, among other factors, high levels of availability and accessibility of illicit drugs indicates a 'minor normalisation' of recreational drug use.

Using Parker's work, Duff has argued for similar trends among Australian youth. Duff provides a more conceptual account of normalisation, arguing that:

just as young people today grow up painfully aware of the risks and uncertainties of modern life, just as they are taught to exercise judgement and individual responsibility in order to prosper in the new economy, today young people feel capable enough to make their own choices about drugs. (2003: 443)

Duff's argument is grounded in the need to understand the "*meaning and culture*" of youth drug use, which, as described above is thought to be connected to individualised modes of consumption.

A growing set of qualitative data suggests that people who use drugs can exercise a shrewd negotiation of the drug's biological effects, its social character, and financial cost (Brain, 2000). Many of the participants in this study indicated a similar negotiation of the pharmacology, sociality and economics of painkiller consumption in their recreational drug use. The impact of neoliberal discourse on normalised drug taking practice is worth elaborating on here. For many of the participants in this study painkillers are consumed because their status as 'medication' allows for personalised recreation in a broader range of contexts than illicit products would allow. Here neoliberal faith in the creative capacity of the individual seems in full operation.

For instance, for Sean and Collin painkillers were a readily available and cost effective alternative to illicit drugs. Analgesics also provide other benefits such as the alleviation of physical and emotional discomfort, allowing Collin to socialise after a sports game and Sean to continue to enjoy his trip after a difficult break up. Similarly, Heidi and Samantha used painkillers to 'change up' their lives and intoxication experiences. The ready availability of analgesics made them appealing for Heidi to reduce boredom when unwell, while for Samantha analgesics were a 'clean' alternative to illicit drugs. Concurrent analgesic and cocaine use allowed Tom to manage his 'high' and sustain his recreation. For Bianca and Jane painkillers provided a way to control illicit intoxication, and to do so without having to face the stigma of visiting a physician. These are examples of personalised consumption developed in order to avoid the perceived pitfalls of illicit consumption. Within these examples neoliberalism appears less as imposing

discourse and more as an embedded part of normalised practices of drug consumption.

One of the key features neoliberal appropriations of normalised drug taking practices is that they can be more personalised, and in many cases are more private than typical accounts of outwardly social recreational drug use. An interesting dynamic between public and private consumption emerged around painkiller use. For the young people in the chapter painkillers are most often consumed in private settings such as the participant's home or the home of a friend. This kind of drug consumption is absent the social aspect that is often associated with recreational drug use. Even when painkillers are incorporated in more recognisable accounts of recreational drug use with amphetamine type stimulants such as ecstasy and MDMA, analgesics are used to whine down rather than amp up the experience. Painkiller consumption thus represents a transition from the public and social recreational drug taking experience back into the private and perhaps intimate setting of relaxation and sleep.

In discussion with young people illicit and analgesic drugs are presented as comparable with the consumption of other consumer products. In this way young people talk about non-medical and recreational drug use in ways that understand painkillers to be a product for consumption in the neoliberal enterprise of free markets. Within the interviews painkillers become normalised products for free consumption.

Conclusion

This chapter has explored the role that painkillers play in experiences of recreational and illicit drug use among a sample of young people. It has discussed the way painkillers are used as intoxicants that provide a 'numb feeling' and allow participants to 'get off their face'. While these practices provide a form of recreational release, it is also key to note how they are tied to the alleviation of forms of physical and emotional discomfort. Likewise, the use of painkillers to 'come down' from other forms of illicit intoxication involves an important component of managing physical discomfort like a racing heart. Such examples of painkiller consumption can be thought of as part of the contextual normalisation of drug use among groups of young people. The painkiller is an everyday product that is an easy addition to the repertoire of recreational and polydrug use of many young people.

Pleasure is also an important part of why and how young people use drugs. For the young people discussed in this chapter the consumption of painkillers was often tied to some form of pleasurable inebriation. Collin and Sean describe a pleasurable 'numb', while Heidi and Samantha talk about enjoying 'being out of it'. Yet for others, like Tom, Bianca and Jane painkillers are used to manage pleasurable experiences with illicit drugs. It is key to note that, for many of the young people who participated in this study painkillers are not static objects whose usefulness is fixed to particular social contexts and subjective associations. Painkillers serve shifting purposes that change from one context to another.

The examples outlined here illustrate the presence of a range of structures external to drug use itself. Participants manage physical and emotional pain through forms of medication consumption endorsed by aspects of medical discourse, youth culture and commercial advertising. For instance, for participants like Collin and Jane the level of pleasure experienced when using illicit drugs is tied to their ability to feel or be 'safe': painkillers provide both the ability to experience illicit pleasure and to be safe while doing so. Analgesic use for a pleasant 'escape' is also comparable to medical and commercial discourse about the medication of emotional pain. Participants spoke about how pleasurable intoxication can "*pick you up a bit*" (Heidi), and "*make you feel better*" (Collin). These are salient examples of the way broadened understandings of pain impact upon contemporary drug taking practices.

The next chapter will explore the relationship between recreational drug use (both licit and illicit) and periods of productive work. It builds on the conceptual discussion of the normalisation of illicit drug use by exploring how forms of drug consumption are encouraged as a reward for 'hard work'. In particular it discusses empirical examples of how painkillers are used to enhance both productive work and related recreational release.

Chapter Six – Work hard/play hard

The significance of working hard in order to achieve financial success has long been a central organising concept of capitalism. Diligent work and financial security are often accompanied by a sense of purpose and pride in oneself. Of course the centrality of work in modern life also has implications for leisure and recreation as people seek to escape from the demands of paid employment. The desire to engage in recreational release is linked in important ways to the modern imperative for productivity. Part One outlined the way medical and commercial interests have turned their attention to the productivity of the modern worker. Whereas Chapter Five spoke about the use of painkillers among a group of young people who engaged in recreational and illicit drug use, this chapter focuses on a broader group of participants who use painkillers for productivity and for recreation. It discusses the use of painkillers at work, as well as to manage episodes of ‘time out’ after work and on weekend break from work.

The chapter draws on interview data from a range of participants in this study, some of whom will be introduced below and others who have been introduced in the previous chapter. It analyses participant descriptions of periods of productive work and recreational release as ‘reward’ for hard work. In doing so the chapter outlines a framework for understanding the consumption of painkillers to enhance everyday cycles of restraint and release in, what is referred to as a work hard/play hard dynamic.

The chapter begins by articulating a conceptual framework about neoliberalism and modern work. Utilising this framework the chapter then

explores a series of empirical examples of painkiller consumption related to productive work. This includes the use of painkillers to 'bulldoze through' physical or emotional discomfort, use to 'deal with stress' and to 'manage sleep'. Less traditional forms of work are also explored through the use of pain medication to 'concentrate while studying' and enhance the performance of domestic labour. The chapter then goes on to discuss the use of pain medications as a form of post-work release in social rituals of 'time out'. A conceptual discussion of the social significance of alcohol consumption as a method of recreation is first addressed, before exploring the empirical examples of participants who use painkillers to 'get more drunk' and as a 'hangover cure'.

Neoliberal work

One significant theme that emerged out of interviews with participants in this study was the use of painkillers to manage their ability to remain productive at work, and while engaging in less conventional forms of labour. The sections that follow will discuss a series of examples of painkiller consumption for the purpose of productivity. Before elaborating on these empirical examples, this section will develop a conceptual framework that helps to explain the role of self-governance in consumption conducive to productivity.

The role of the neoliberal philosophy in economic and social policy has had important implications on the structures of modern work and paid

employment. As outlined in Chapter Two, neoliberal policies have formed part of processes of macroeconomic reform pursued by governments and a transnational business elite over the last thirty years. Social researchers have also noted that neoliberal emphasis on 'flexibility' in industrial relations has often translated into a reduction in the rights of the individual worker (Smith & Morton, 2006; Palley, 2005). As a result the working world is increasingly made up of casual and short term contracts. The requirement to work harder and to demonstrate your worth to current and prospective employers, who are under fewer obligations to provide stable working conditions, is one of the lived realities of neoliberal work.

It is important to note that fractured and uncertain employment impacts on the way work is governed and experienced. Short-term and casual contract work has made employment less secure in industrial societies (Barbieri, 2009; Bauman, 2007). Advances in computing and communication technology have also played a significant role in reshaping experiences of and expectations about work. The enhanced role of the internet and a proliferation of mobile computing devices have increased the speed and expanded the terrain of 'work' (Freeman, 2002; Baily & Lawrence, 2001). These conditions of employment invariably inform the way work is experienced. Indeed the demands of modern work are increasingly described as stressful and headache inducing (Harkness et al., 2005) and an entire research literature has developed around the "work stress 'epidemic'" (Gregg, 2011; Wainwright & Calnan, 2000).

Levels of stress at work, and the bodily responses that accompany stress, have also been presented as impediments to the productivity of the

modern worker. Political rhetoric has constantly represented the productivity of the Australian workforce as being in decline “since the record highs of the 1990s” (Parham, 2012: vii). Medical and commercial responses to stress-induced-illness or discomfort often foreground biological considerations. Chapter Four already outlined how medical discourses present (headache) pain as an impediment to self-expression and social participation. It also outlined how consumer discourse borrows from the notion of pain as an obstructing force, positioning the purchase and consumption of over-the-counter (OTC) analgesics as a remedy to pain’s obstruction of self-fulfilment. Many direct-to-consumer advertisements for OTC painkillers involve depictions of office workers who are incapacitated by the pain of a headache. Alongside the relief of physical pain, the consumption of Panadol or Neurofen is also presented to be a way to return to the worker the capacity to be productive.

By presenting stress as an individual biological response with a pharmaceutical solution, medical and consumer discourse can obscure the social determinants of work-related-stress. This process borrows from long traditions of medicalisation that construct socially undesirable or inconvenient bodily responses as medical symptoms (Conrad & Schneider, 1992). However the increased commercialisation of medical discourse introduces a new element to the landscape of medicalisation scholarship. The concept of ‘pharmaceuticalisation’ has recently been developed to aid in the analysis of the entanglement of medical and consumer discourse.

Sociologist Melinda Cooper (2008) has argued that the ‘neoliberal turn’ during the 1980s coincided with a series of creative transformations

and technological advances in the life-sciences. Cooper notes that the technological advancements in molecular, cellular and microbiology during the era of neoliberal reform have created an “intense traffic between the biological and the economic spheres” (2008: 4). As a result medical, biological and economic development over the last thirty years has often involved shared interests, skills and social networks. This has fostered a close relationship between the medical profession and the biotechnology and pharmaceutical industries (Clarke et al., 2003).

Overlap between medical and commercial interests has also informed analysis about medicalisation and pharmaceuticalisation of productivity at work. In theorising the use of medications in contemporary working environments Keane observes:

Discourses of productivity and flexibility construct a regulatory ideal of an adaptable, alert, multitasking worker... At the same time the discourses of enterprise and excellence that have flourished in neoliberal economies emphasise the continual improvement of work performance... One consequence of these trends is the problematisation and medicalisation of traits that interfere with optimum performance and efficiency. (Keane, 2011: 109)

Keane elaborates on the role of the individual in negotiating these processes of medicalisation by borrowing from Rose’s notion of ‘biological citizenship’; a concept which suggests that the individual is made responsible for and becomes responsive to biological considerations (Rose, 2009). Keane argues

that, as a result of neoliberal influences on working conditions “pharmaceutical self-management [has become] an attribute of the responsible worker” (Keane, 2011: 117).

The convergence of medical and consumer discourse in the context of neoliberal working conditions has promoted the desirability of a pharmaceutically induced productivity. The sections that follow will provide a series of empirical examples of painkiller consumption related to productivity and work. The examples outlined in this chapter do not form a direct relationship with biomedical frameworks for medication consumption: instead they borrow from and appropriate contemporary forms of legitimate medical discourse.

Bulldozing through

The need to stay productive at work in the face of physical illness or in anticipation of illness was a significant point of discussion among interviewees. Some participants spoke about the pre-emptive use of painkillers to avoid feeling unwell. ‘Tony’, a 28-year-old Operations Manager from Perth, spoke about the use of painkillers to remain productive at work in particular detail. Tony is single and takes his job very seriously, doing most of his work from behind a desk in the company’s inner-city office: “*I work 8 hours a day, five days a week, staring at a screen*” (‘Tony’ – Interview, 2 June 2012). His job involves managing a small team of people to meet tight deadlines.

Tony's job was often a cause of headache inducing stress, and painkillers play an important role in making sure he could keep working. The kinds of physical discomfort that result from his work included 'dizziness' and a 'throbbing forehead': *"it's like a small dizzy spell or just a throbbing from staring at the screen for too long without taking a break"*. Tony also spoke about the use of painkillers in anticipation of feeling unwell: *"if I'm starting to feel even slightly unwell I'll take a couple [of Panadols], just to try and sort of bulldoze through"*. Tony explained that he commonly used Panadol to 'bulldoze through':

There has probably been several occasions... where I've been working working working, staring at the screen for say an hour or two at a time and I don't know like - it is just almost like a faint feeling in my head. It wasn't quite tiredness, but it was just like lack of energy almost. But just felt slightly disorientated and I guess the first reaction was to go and grab a couple of Panadols from the staff cupboard.

if I start to feel like a spell coming on the first thing I normally do, without normally doing anything else, is to start going into the kitchen and grabbing a couple of Panadol. And look normally it works. Just as I said bulldozes through. Whether it is an actual headache or it's something else, the Panadol just sort of bulldozes through anything really.

For Tony, Panadol is an entirely innocuous device he used to get through the day, and the workplace itself provided a legitimising context for this kind of consumption. The staff cupboard is “*always stocked*” with Panadol and employees are free to consume its contents with little to no scrutiny from management. Though Tony conceded that a short walk and some fresh air might have the same effect, a pharmaceutical intervention is usually the most convenient option.

A 35-year-old office worker from Sydney named ‘Michael’ also used painkillers when trying to regulate his productivity. Michael is employed on multiple casual and part-time contracts for companies in different industries. This makes for a busy schedule that often leaves him tired and run down. When explaining a particularly stressful week that had just gone past, Michael recalled: “*It was probably on Sunday. No it was Saturday. I had to do something or meet somebody. I’ve been to too many work-places this week. Yeah I was just thinking am I going to be able to cope getting up on a Saturday?*” (‘Michael’ – Interview, 4 July 2012). Having already had a busy week, Michael was worried about his ability to perform at a meeting on Saturday morning. He contemplated taking a painkiller to help him sleep, but decided against it to avoid “*feeling groggy*” in the morning and “*looking a bit sloppy*” at the meeting. Instead Michael took some Panadol the morning of the meeting: “*So I took it before I left and had my coffee and got motivated to work*”.

Michael describes himself as “*hyperactive*” and said that is sometimes an impediment to his work. He explained “*I’m one of those people who picks up a lot and sees a lot. I’m very hyperactive as it is*” and that painkillers help

to “*shut that hyperactivity down*”. Michael goes on to describe how his use of painkillers to dull hyperactivity helped him ‘get in the zone’ for a period of productive work. He recalled that sometimes he took painkillers “*Just to blank out. It blanks out a headache. I just [take] four before work ‘cause I just wanted to be in the zone*”. Recalling one morning where he had a lot to do, Michael took Nurofen and Disprin “*before I left [for work] and had my coffee and knew I would be motivated*”.

When using painkillers before work Michael preferred to take Nurofen because “*I don’t usually dump pain relievers with water, it’s usually like straight down the hatch. With Panadol it was like ‘errk.’ But those [Nurofen tablets] were like sugar... they tasted like lollies to me*”. His preference for Nurofen is explained as such: “*I’m highly addicted to sugar. So anything with a bit of sugar in it. [Nurofen’s] got that sort of a bit sweetish, or better flavour*”. Michael did however go on to describe some contradictory feeling about his experiences with and use of Nurofen. Due in part to a back injury he sustained several years earlier, Michael began using Nurofen on a regular basis for a period of approximately two years, which he says was “*doing a lot of damage*”. Three years prior to interview Michael was diagnosed with reflux after an uncomfortable night he had to visit to the local hospital’s emergency ward: “*The stomach was leaking. And that was due to using too much iBuprofen for about a period of two years*”. Michael said that he now uses Nurofen more judiciously, but will often keep it in mind if he has a busy schedule.

Dealing with stress

Work-related-stress is also a key motivation for painkiller use at work among participants. While stress was an important part of why Tony and Michael use painkillers, a participant named 'Ray' spoke directly about responding to stress by taking painkillers. Ray is a 45-year-old Australian man, who has done shift work for most of his career. Five years ago Ray left a telecommunications company that he had worked for since he was 30: "*I was there for like 10 and a half years, and I was happy for the first seven. Then I probably left it a bit too long to find something else to do*" ('Ray' - Interview, 2 October 2012).

Working with difficult customers, usually over-the-phone, proved an unwelcome source of stress for Ray: "*it was always 'what nasty customer am I going to get today?' So you always think something bad is going to happen*". But it was not just the customer that put Ray on edge at his previous job. He recalled that "*I work[ed] with people that, if they got a nasty customer, they would just genuinely explode. Thump the desk. Start screaming fuck this! Fuck that! And then run off half mad and have a cigarette*". When Ray felt intimidated by the situation, he often took painkillers to relax: "*It just made me numbed for a bit, made me more relaxed. So that if they blow up I can just think 'its nothing to do with you. Relax. Don't take it personally'*".

Since leaving the telecommunications company Ray has taken casual shift work as a security guard. Ray's use of painkillers has been less frequent in this new position, though he does still take them when they are available. With reference to his new job Ray recalled: "*If I've run out of them, I won't*

buy more until I'm actually feeling sick. But then if I've got like a box of 24 in my bag, that's when I tend to take them for just stress and things like that". He recalled taking painkillers before work, as a way to prepare for a difficult day:

It's not just after something particularly bad has happened. It's usually at the start of the shift and I'm just like, "Don't wanna be here. Gonna get a coffee. Have Panadol with the coffee? Yeah". It just makes sure that you're covered for the shift, if it gets too stressful.

When elaborating on this kind of pre-emptive use to deal with stress Ray also made comparisons to the way he might consume confectionaries:

It was about 8'oclock, I started at about 7[pm]... Had a coffee, had a cigarette and then I'm like "I think I have Panadol in the bag". I didn't have a headache or anything like that. Its just 'cause I had it there and I just remember, its like having a bag of lollies in the bag or something.

When asked to elaborate on the comparison to a 'bag of lollies' Ray went on to say: *"I didn't need Panadol if that makes any sense. I just wanted it. Same way you don't need a jelly snake unless you're diabetic or something. You know, you just want it".* Here Ray highlights the way Panadol (and other OTC painkillers) are presented and used as consumer products. This has important links to the way sociologists have described the connection between medical and commercial discourse. The capitalist economic system

produces forms of social anxiety and suffering, for which consumer products are presented as the solution.

Managing sleep

Similar accounts of pre-emptive consumption emerged around the use of painkillers to manage sleep in order to be alert the next day. Lack of sleep has been described as a significant consequence of work related stress (Chatzitheochari & Arber, 2009), and the harmful consequences of disrupted sleeping patterns are a significant component of the stress literature (Åkerstedt et al., 2002; Steptoe, 2006). However benzodiazepines (commonly referred to as 'sleeping pills' or 'tranquilisers'), not analgesics are most commonly prescribed for the regulation of sleep. Two participants in particular described the use of painkillers to get a good night's sleep when stressed. This section will elaborate on interviews with a woman named 'Mary', as well as return to aspects of Tony's use of painkillers.

Mary is a 39-year-old Vietnamese-Australian woman who arrived in Australia during her late-teens. The last decade has been a difficult time for Mary, who has a very different life now than she did ten years ago:

It was very bad before, because I went through divorce, I end up in the criminal refuge because of domestic violence. And I studied at University with my little boy, he was really young, just born. He got sick all the time.

My second son passed away. A lot of stress happened in the last ten years.

(‘Mary’ – Interview, 20 April 2012)

As the mother of a young boy at primary school, negotiating the burdens of single motherhood and the demands of a fast-paced professional environment is important to Mary. Trying to strike the right balance is a stressful task. When describing the physical sensation that accompanies stress, Mary said:

very funny pain when you are stressed. You feel pain but you don't know where. Sometimes it's not a headache, it's not a shoulder, it's not a belly-ache. It's just pain, but you don't know where. That's how the stress comes.

When feeling stressed, painkillers are one of the ways Mary makes sure she can manage her schedule.

Mary has worked in various administrative positions for the better part of 10 years and at the time of interview her job always involved a looming deadline. Recalling a particularly busy period a year earlier, Mary said: *“I [knew] that my schedule tomorrow [was] going to have a deadline... and I was like ‘oh no, I need to have a good sleep to prepare for tomorrow’. And I thought I should take a painkiller”*. Describing the relief that the OTC analgesic Nurofen provide when she is stressed out and needs to sleep, Mary said:

Straight after I'm taking the painkiller, 5 minutes or a couple of minutes after that I feel good. I feel comfortable. Because I already prepared for the stress. Even if the stress is not pain yet I feel comfortable, I feel ready for it. When I go to bed, I take a painkiller and think "ah, I can relax now because I'm gonna have a very good sleep".

Her use of painkillers to get a 'good sleep' forms part of a wider story about her need to be productive. Mary anticipated her schedule and decided whether 'good sleep' is required for productive work the next day: *"I still have to take a painkiller before bed, and during the day if I've got a deadline. You know I have to take it to concentrate".*

Tony also spoke about taking painkillers to regulate sleep, saying that he had not always been so focused on his job. Up until only three years ago Tony had spent a lot more time with his then partner, who remained an elusive figure in the interview, except to say that he did not take their breakup well. Tony reflected that *"it just made me very sad, because she was just gone and I didn't know what do with that".* Tony threw himself into his work but found it difficult to get into a healthy sleeping pattern: *"I was basically not sleeping at night because me and my partner went our separate ways after nearly a year".*

In an attempt to better regulate his sleeping pattern Tony went to a GP who prescribed sleeping tablets. While they worked at first, it became difficult to sleep comfortably without them: yet he resolved that *"it was fine, now I've stopped using them as much and it's fine".* One of the other techniques Tony adopted to regulate sleep after the breakup was the use of

painkillers: *"You know like on nights where I'm feeling particularly stressed or if I need a good night's sleep or if I haven't been sleeping well lately"*. Similar to Mary, the ability to sleep well the night before provides Tony with the certainty that he will be able to concentrate the next day.

Concentrating while studying

Professional or paid employment was not the only kind of work that participants spoke about. Interviewees also spoke about the use of painkillers to be productive while engaging in unpaid or less traditional forms of labour. For a 25-year-old participant name 'Jason', painkillers are used to assist with levels of concentration when studying for university assignments. Jason was born in Colombia and came to Australia to study in 2008. He had ongoing issues with his Australian visa and was only been able to secure unstable or casual work. His visa and work situation contribute to stress and anxiety that becomes difficult and distracting when assessments are due: *"I was down a little bit because I was stressed. I was stress because I couldn't find a job, I was stressed because I didn't understand the units I had to do, the assignments. Everything, the [Australian] system is completely different"* ('Jason' – Interview 2, 2 October 2011).

In order to inoculate himself from the stress Jason uses painkillers: *"I always try to keep medicine in my bag. I always have something in my bag just in case"*. Jason takes painkillers such as Panadol and Nurofen to avoid feeling physically run down or getting sick: *"when you feel sad and stressed and stuff*

like that your body also responds to that, so you feel down and feel you are going to get sick". He described the effects of painkillers as helping to make his body feel relaxed, making him less susceptible to the discomfort of feeling anxious: "So sometimes when you take something you know at least the body is going to feel better, even though your thoughts are still going to be there".

During a period of unstable work a few years earlier Jason had to move from his apartment unexpectedly. After moving into a new apartment Jason met a roommate who offered him some Panadeine Forte to cope with his clashing study commitments:

Yeah she was also living there and she said "ok I take this one when I'm really stressed... when I have too many assignment and when I have too much university stuff". And she gave me one packet. But it finished very quickly.

Jason said that they helped him "*concentrate more*" without "*worry[ing] too much about things and getting headaches*". Jason also worried about his English proficiency and how it affected his performance at university. Recalling a particularly busy period later that year Jason says: "*first of all it was a difficult topic, second it was in English and English is not my native language. So sometime – when you know what you want to say... but you don't know – you don't find the words*". Jason was not working at the time either, and this compounded his concern about the demanding workload: "*Yeah*

and that makes it more stressful, and the teacher was very very demanding. Was very strict with us. So it was like a lot of things, where I felt like in shock”.

Jason’s inability to focus on university work is linked to a range of circumstances, such as stress from uncertain financial, visa and housing arrangements. His use of painkillers ensured that he can maintain concentration in order to get his work done.

Taking care of the kids

For many of the women who participated in this study a significant reason for the non-medical use of painkillers related to their ability to manage domestic responsibilities. The need to find ways to be motivated for and physically able to care for small children was an important theme in the interviews. ‘Sarah’ is one participant who spoke about the use of painkillers related to her ability to take care of her children. As a young mother of 20-month-old twins, Sarah had a lot on her plate at the age of 18. She lives in a rural town in NSW, where she has spent most of her life. After leaving high school in Year 11 to raise her children Sarah worked odd jobs in retail but often found it difficult to get a babysitter, and has had to rely primarily on her partner’s income to support the family. Sarah mostly uses painkillers when she gets a headache.

When describing a particularly difficult day at the funeral of a close family member, Sarah explained that she was having a hard time coping with the stress of the loss while having to take care of the children and deal

with some financial issues. During a period of commiseration with her family Sarah's children were *"just being really naughty and they were sick as well"* ('Sarah' - Interview, September 24, 2012). To top it all off her partner informed her that he had just lost his job: *"so I was really stressed about money and didn't know what we were gonna do"*. The situation became overwhelming and Sarah suspected that it was responsible for the nasty headache that soon developed. She recalled taking a prescription analgesic named Mersyndol because it was the only medication offered to her by the family member whose home they were visiting at the time.

Sarah recalled that she did not think that the pain warranted a prescription painkiller, but that the extra strength medication did help her deal with the situation: *"it just let me relax and let me think about the problem better"*. She said that use of Mersyndol made her more patient with her children at a time when they needed her to be patient: *"like they were sick and upset as well, so after the Mersyndol I was just like more relaxed and could give them more attention you know"*. Sarah goes on to reflect, *"like it didn't really fix the situation or the problems but it made me look at things in a different way"*. For Sarah, the extra dose of analgesic allowed her the physical and mental utility to be there for her children. As a result, Sarah also started using prescription analgesics to more thoroughly remove the symptoms of a hangover, so that she would feel up to entertaining her young children the morning after a 'big night'. Use of painkillers to manage a hangover will be dealt with in more detail later on in the chapter.

Other female participants also described painkiller consumption as a social cue that could provide productive distance from the responsibilities of

taking care of the kids and other domestic duties. The need to 'get away' was an important part of the way some women are able to sustain the demands placed on them. 'Jenny' is a 33-year-old mother of three children who injured her back while serving a tour in the armed forces in her early twenties. She is often prescribed morphine and other analgesics related to the injury, and has used them quite a bit over the last fifteen years.

One of the other main reasons Jenny has used painkillers is the migraines she started to experience after she had children: *"about twelve years ago my first thing, a mother having children I had a lot of headaches, I suffered from migraines and I would take at least eight Nurofen a day through the day so I wouldn't have a migraine"* ('Jenny' - Interview, April 23, 2012). Sometimes the combination of her injury and the stress of domestic responsibilities would collide in ways that were particularly difficult. She recalled one time when *"my children were sick. I was sick. I was in pain. And I was around my parents who were just not helping at all... and because the stress had escalated so much that my back had gone out"*. On occasions such these, morphine became very useful.

Jenny recalled that a few years prior to interview her use of morphine started to become a bit of a crutch. Due to a range of factors that seemed to collide all at once her use became more frequent: *"Ok, a mother of three, a husband that's in the services that's away a lot. I am an ex-army soldier, there was a lot of things. I didn't have a job, I didn't have an identity"*. While much of her use of morphine was still related to the injury, she went on to say that other factors also began to play a role:

Because [when] I was on it, people knew that I was on it for a reason... It made it easier to just lay around and be in pain I guess. I slept a lot with it so when I slept no one bothered me. No one came and wanted me to do anything so it was easy to escape life.

Jenny went on to explain that her pain has since improved. She has been tapered down to a lower dose pain medication and is using them less than she used to.

'Jessica' is another participant who had a similar experience to Jenny. Jessica is 41 years old and worked a demanding administrative job at a local business. She is also the mother of two young boys under the age of 10. Jessica had been prescribed analgesics for several years in relation to a series of "clumsy accidents" while "camping with the family" and "taking the kids for a walk" ('Jessica' – Interview, April 23, 2012). However she also took her prescribed medications when she got migraines: "Well I suffer from chronic migraines, so a lot of the time I use pain medications for that". Jessica's migraines are often exacerbated by stress related to domestic responsibilities. She recalled how she used Mersyndol Forte a few years earlier:

It would probably have been in the school holidays, 'cause I was on holidays at the same time. [My husband] decided he was going to clean out the fridge so I was taking care of the kids... And he'd pulled everything out of the fridge and was wiping the shelves down, but he left the fridge door open and it was beeping. And I said "just shut the fridge

door before you clean everything out". And he said "oh no its not bothering me". And I went "yeah but it's really bothering me". So I ended up taking some Mersyndol Forte and taking myself off to the other side of the house again, just to get away and also to calm down.

She explained, *"So I guess I tend to take the pain medications for stress as well as the pain"*.

Jessica also reflected on the complexities of her use of painkillers to 'de-stress'. She wondered about whether her use of analgesics had been motivated by more than simply wanting to ameliorate migraine pain. The way the stress of her domestic life impacted on the presence of migraines was a point of contention. The following exchange from the interview details her concern about migraines and medication consumption:

Jessica: I mean it's possible that the headaches or migraines that I was getting were more psychosomatic.

Researcher: Why would you say that the migraine's were psychosomatic?

Jessica: Just maybe because I was feeling really really tense and was almost expecting a migraine to come. I was almost anticipating it and medicating before-hand.

Here Jessica described a kind of pre-emptive consumption that is comparable to the way other participants discussed thus far have used painkillers to avoid illness or headache pain at work. However the discourses of productive consumption that frame the narratives of people who take painkillers to avoid headaches at work are less available to Jessica, whose domestic responsibilities are regarded as a less legitimate form of work.

Jessica goes on to explain that her painkiller consumption has now evolved from use for migraine pain to use for relaxation: *“So I was taking the painkillers as an excuse to get away. Whereas now I recognise that ‘ok so I need to take something to calm me down”*. It is however important to note that there are significant overlaps between the forms of use Jessica described. The presence of migraine pain may provide a legitimising biomedical framework, but the reasons for Jessica’s analgesic consumption remained largely consistent. Though the presence of migraine pain may no longer be necessarily to initiate Jessica’s use of pain medications, she still took painkillers *“to relax”* and *“to be left alone”* so that she is better able to fulfil the responsibilities of domesticity and motherhood: *“I just can’t keep up unless I have at least some time to myself”*.

As noted in the conceptual discussion about work and productivity at the outset of this chapter, medical and consumer discourse form part of neoliberal modes of governance that tacitly endorse pharmaceutical self-management. The empirical examples discussed thus far demonstrate how individual consumers adopt and appropriate legitimate notions of biomedical impediment to productive work. Participants in this study

anticipate forms of physical discomfort likely to interrupt work, study and domestic responsibility, and they pre-empt it through self-medication.

Neoliberal play

When the working week is done it is common to recover and unwind with a night out on the town, often with the goal of intoxication. Intoxication allows for a pleasurable release from the constraints of the working world, which, as we saw above, can demand dedicated periods of restraint for productivity. This kind of ‘time out’ ritual has become an important part of contemporary understandings of productivity. Neoliberal notions of productive work are closely comparable to social expectations about recreational consumption. The neoliberal subject is expected to engage in recreation that does not interfere with productive goals. While the previous sections have outlined the ways painkillers are used to ensure or enhance productivity, the remainder of the chapter will explore the ‘time out’ rituals that foster a continuation of cycles of restraint and release.

Forms of pleasurable ‘release’ are a central part of contemporary debates about the normalisation of drug consumption, briefly canvassed in the previous chapter (Parker & Williams, 2003). Research suggests that young people develop an enterprising relationship with the drugs they consume, one that takes into consideration its physiological effects, social identity and financial cost (Brain, 2000). The normalisation of alcohol consumption does however involve a set of specific forms of socialisation

and involves a different kind of political economy of consumption to that of illicit drug use. Illicit drug use can only be understood as normalised within particular social contexts and among a selection of subcultural groups, many of which are defined by their subversive character: rave culture (Duff, 2003), the club drug scene (Fazio et al., 2010; Shacham & Cottler, 2010), and street or gang culture (Sanders, 2012) are key examples. By contrast, in Australia the consumption of alcohol for the explicit purpose of intoxication is viewed as a widely acceptable, and even expected form of social lubrication (Australian Institute of Criminology, 2009).

Research into alcohol is most often concerned with its consumption among young people in night-time entertainment districts. Speaking about the British context Hobbs writes that:

Alcohol consumption provides both a culturally and legally sanctioned way of altering behaviour, and it is this opportunity to enjoy legitimised 'time out' in the form of hedonistic forms of experiential consumption and identification, that renders the night-time economy so alluring to young people. (Hobbs, 2003)

Similar arguments about the Australian context are well established, with research focusing on alcohol related violence in the night-time economy (Tomsen, 2003). Tomsen and colleagues write that the Australian night-time economy is “focused around ‘time out’ periods at night and towards or during the weekend, and are centered on entertainment areas and venues” (1990: 4). Night-time entertainment districts in Australia are thus made up

of venues like bars and pubs, designed both socially and economically around the consumption of alcohol (Miller et al., 2013).

The regulation of alcohol has been progressively liberalised for several decades. Australia's road to the liberalisation of alcohol gained momentum in the second half of the twentieth century (Filmore & Roizen, 2000), which began in the response to tightening regulations on analgesics and other drugs. Recent moves towards the liberalisation of alcohol regulation, now available for sale by large supermarkets, seem to confirm the at least partly depoliticised status of alcohol. In a recent series of reports by NDRI, the level of alcohol consumption in all jurisdictions is thought to have exceeded ABS estimates (Loxley, Chikritzhs, & Catalano, 2011; Loxley, Chikritzhs, & Pascal, 2009). Forming an important part of the operation of the night-time economy, escapism through alcohol intoxication, often in the form of binge drinking, is now thought to often be "the norm rather than the exception among young people" (Harrison et al., 2011: 469).

Today the consumption of alcohol is regulated in market-based policy structures that competitively encourage maximum purchase and consumption. Though excessive alcohol use certainly attracts stigmatisation (Fortney et al., 2004; Room, 2005), the drug itself is largely excluded from such stigmatising discourses. Despite public controversy surrounding alcohol related violence, alcohol's at least partly legitimised status means it is still presented as safe in moderation. Consumer and public health discourse present alcohol as safe in moderation and thus permissively endorse its consumption as the drug of choice for social rituals of 'time out'. Public health approaches to alcohol often incorporate the notion of the

'responsible drinker'. Aspects of the public health response to alcohol thus rely on neoliberal notions of the rational consumer, who is required to manage appropriate forms of recreation (Harrison et al., 2011; McCreanor et al., 2005).

Alcohol consumption is a state sanctioned and socially acceptable way for the neoliberal subject to fulfil his/her duty to consume as part of cycles of production and consumption. The remainder of this chapter will explore the way people consume alcohol as 'release', and how painkillers are used as part of this process. The combination of alcohol and analgesic medications to 'get more drunk' is a key example. The use of pain medications to quickly or more effectively return to a productive state after heavy alcohol use will also be explored.

Getting more drunk

Many of the participants in this study used alcohol to unwind after a busy week, and some spoke about using painkillers to enhance their experience with alcohol. Combining alcohol with painkillers is described as an enterprising way to enhance intoxication without having to resort to the expense of purchasing more alcohol or difficulties of acquiring illicit drugs. Accounts of concurrent alcohol and analgesic use involve similar narratives to those produced by the young people who use illicit drugs, which were developed in Chapter Five: painkillers are presented as a convenient, commonplace product that can be drawn upon to manage or enhance

experiences of intoxication. There is however the important element of the licit status of both alcohol and analgesic medications that produces its own kind of a legitimising discourses among participants. An interview with a participant named 'Elizabeth' highlights some of the similarities, as well as difference, between participant discussion of illicit drug and alcohol use in combination with painkillers.

Elizabeth was born in Hong Kong but has lived in Australia since she was a very small child. At the age of 32 Elizabeth now works a demanding job at a marketing company. Despite brief mention of being "*snowed under at work*" ('Elizabeth' - Interview, April 24, 2012) Elizabeth did not seem all that interested in talking about her job. She was however very comfortable sharing vivid accounts of binge drinking and other forms of intoxication, which seemed to form a regular part of how she spent her weekends and other leisure time. Most of the discussion with Elizabeth surrounded recreational drug use, including alcohol, ecstasy, and painkillers. Plainly, she said that she enjoys "*being messed up*", but only "*in the right setting. Obviously I wouldn't enjoy it if I was at work*".

Elizabeth goes on to explain that she would not find pleasure in using painkillers in a professional setting because when taking them, as she put it, "*I can't concentrate. I can't really function. I can't really think straight*". This loss of functionality is only described as desirable in the context of a night out:

Like many people probably won't wanna dance until they're a bit more drunk or a bit more messed up. So I feel like I can enjoy friend's company

a bit more. Especially if they are all high on illegal substances and they're all having conversations that are not that entertaining. It makes me more inclined to find it a bit more entertaining.

Here Elizabeth described a general context of casual night-time enjoyment, which is likely to involve licit and illicit drug use among herself and her friends. Painkillers are one of the substances she uses to get a “buzz”, which she described as *“feel[ing] kind of like dizzy and light headed. Kind of like when I’m on other recreational drugs”*.

Yet much of Elizabeth’s discussion of analgesic use was when mixed with alcohol. She described several examples when out with friends who had taken ecstasy, but she either could not afford to join them or simply did not want to use illicit drugs that night. Elizabeth recalled one night when combining Panadeine Forte and alcohol in place of ecstasy:

it was my friend’s birthday and they we’re all taking [ecstasy] pills. And we went out to a club on Oxford St... I wasn’t really feeling up for going out, and otherwise I would have just headed home. And I didn’t even drink that much that night after taking them [Panadeine Forte]. We [ended up being] out until six in the morning just dancing.

This became a common trope: *“So basically I just usually use them when I’m out in a pub drinking or something... I would just take like two Panadols or I’d take like even a Panadeine Forte, and I’d feel a bit of a buzz”*. Through the combination of painkillers and alcohol Elizabeth could more easily, and

cheaply, enjoy dancing and having “*silly conversations*” with friends, because it constituted a controlled loss of the control that operates in her everyday life. The night out is after all where, as she puts it, “*I’m meant to [be] doing that sort of stuff*”. Painkillers like Panadeine Forte and Panadol also provide the opportunity to feel intoxicated without the risks associated with being very drunk. For Elizabeth, intoxication is the goal and painkillers were simply a “*cheaper way... to get more drunk*”.

A framework about the use of alcohol and painkillers to be more sociable also emerged from an interview with a participant who sought ‘release’ from periods of intense study. ‘Henry’ is a talkative 25-year-old who is an Arts graduate from a prestigious university. Tertiary education was a defining period for Henry, who described it with nothing but fondness. As a self-confessed more-awkward-than-most teenager, university was where Henry came into his own. Many of his enduring friendships were made during his time at university. Closely related to the social aspects of his time at university was the way in which friendships were forged through a joint commitment to periods of productive study and subsequent release: “*When I was studying for uni I found that I really wanted to go out on weekend because it’s kind of Monday to Friday and Sunday that I did my study and I wanted to be able to have a bit of a break*” (‘Henry’ - Interview, 2 September 2012).

Perhaps typical of university-educated men in their mid-twenties, Henry had a nonchalant attitude to intoxication and pleasure-seeking through drug consumption. This was most clearly articulated when Henry spoke about drunken nights and drugged out adventures “*back in my uni*

days". Having seen his sister lose her life to heroin, Henry was however careful to mention that he had only occasionally taken illicit drugs, "*just experimentally and stuff*".

Recent debates about how best to describe periods of intense drinking on the weekend have provided critical theoretical accounts, as well as empirical evidence for, the conceptualisation of this type of consumption as a form of 'calculated hedonism' (Szmigin et al., 2008). This involves patterns of measured but intense consumption that allow for a sense of controlled loss of control (Measham & Brain, 2005). Henry's approach to drinking and drug use can be partly explained by this kind of purposeful and directed binge consumption that remains contained to very particular conditions, such as after the completion of his exams and only with friends who have also completed similar milestone assessments.

During his university days, Henry frequently mixed alcohol and painkillers because, as he puts it, "*you get drunk a lot faster*". He recalled one night when he went out to celebrate finishing his exams at a local bar: "*It's about 15-20 minutes' walk from the university... We went out and played some pool, listened to some music. They had some pretty cool computer games as well*". Described as a fairly standard night at the "*uni bar*" Henry recalled:

[I] had about 12 drinks that night. There were about eight of us there from different years from uni. Different subjects as well. After we got to the bar we kind of broke up into three different sections. A few people played pool and a few people hung around the bar. I kind of jumped back and forth and in between.

After discovering a sheet of Nurofen Plus that he had left in the pocket of his pants, Henry and his friend 'John' decided to take a few with their next drink.

Reflecting on his decision to take the Nurofen Plus while drinking Henry said *"it wasn't illegal what we were doing. But I suppose it was the sense that maybe we were doing something morally or ethically which was a bit left of centre and it might have been frowned upon"*. However when it came to painkillers Henry found comfort in the way the product was made, saying that painkillers are *"a quality product, by a quality pharmaceutical company. Similar thing with the alcohol as well"*. His description here clearly represented an extension of the notion that painkillers are 'safe', but he went further, blurring the line between the kinds of practices that they are safe for: *"I've drunk alcohol before. I've had Panadol before. Surely it wouldn't hurt that much by combining the two"*. While combining alcohol and analgesics may have attracted some transgressive appeal, his use of these licit products was largely about enhancing an entirely normalised social practice: *"I was using them to get more drunk"*.

A lot of other participants, including those introduced in the previous chapter, also mixed alcohol with painkillers. Heidi, a 27-year-old Irish-Australian woman recalled that she used to combine alcohol and painkillers when she was younger: *"[its] like being drunk, but better"*. She says that she often used painkillers in this way on a Friday night after work, explaining that *"alcohol is a lot more expensive"* and that *"painkillers make a good alternative to just buying heaps of drinks"*. Sean, also introduced in Chapter

Five, said that when mixing painkillers and alcohol *“you get drunk quick”*. He recalled that the effect of the painkillers is different when taken with alcohol: *“it’s not so much a painkilling effect, it’s just that the drink is more effective. So you have a glass and you feel like you’ve had three”*. This was described as a particularly good way to relax and enjoy the weekend: *“Things are good, you get chatty, and you loosen up. ‘Cause it can be awkward if you’re out socializing”*.

The examples presented here demonstrate how practices of ‘controlled consumption’ for pleasurable release are often produced in response to periods of productive restraint. Elizabeth for instance specifies that *“being messed up”* is inappropriate for work and that periods of ‘time out’ are when she is supposed to *“do that sort of stuff”*. Similarly Henry notes a distinct ritual of alcohol (and painkiller) consumption in response to periods of productive study. Other participants who use painkillers in combination with both illicit drugs and alcohol also provide important insight into the need to engage in a form of ‘controlled release’. There is however more to the combination of alcohol and painkillers than notions of release. Painkillers are not simply another way to become intoxicated. When compared to illicit drug use, painkillers are better suited to legitimate frameworks of personal consumption for pleasure.

Mixing painkillers with alcohol is seen as an acceleration of the effects of alcohol without the expense of increased alcohol consumption. The knowledge that painkillers are manufactured ‘safely’ is also an important driver of non-medical consumption with alcohol. Both products are seen as sanitary and thus in many ways safe, at least in relation to illicit drugs. For

those who make comparisons to illicit consumption there is also an extra layer of personal, legal safety attributed to painkiller use. Painkillers are more commonplace than illicit drugs, and as such they are more available, and safer to acquire and possess.

Hangover cure

The use of painkillers to relieve the symptoms of a hangover was also discussed among a wide range of participants. The example of the hangover provides an important insight into the way periods of productive work and recreational play are connected; how they form part of the same cycle of restraint and release. Thus far this chapter has discussed the use of painkillers to manage productive performance and to enhance periods of 'time out'. It is however significant to recognise that periods of productivity and release both form part of broader experiences of everyday life. Forms of self-medication for discomfort resulting from heavy alcohol consumption play an important part in the social organisation of people's lives. While the pursuit of pleasurable intoxication is a common and expected part of the way participants took time out, they also required quick recovery from heavy alcohol use in order to be able to continue to function productively.

For some participants who use painkillers to remain productive, analgesics also provided an easy opportunity to relieve hangovers. Michael, who was introduced earlier as someone who uses painkiller to 'bulldoze through' at work, also mentions incorporating analgesic consumption into

his routine when drinking. When recalling what he does while drinking, Michael said:

So I'm drinking and I'll do a preventative, so I know I'm not going to get it. 'Cause I'm a shocking hangover person and shocking headache person. So a lot of preventative taking. Sometimes I think "oh I'm going to get a headache or hangover" - who knows if I was or wasn't.

The kind of preventative use he describes when anticipating the symptoms of a headache at work are extended to the way he manages hangovers.

The use of painkillers for hangover pain also raises interesting questions about what constitutes medical use of an analgesic. While using painkillers for headache pain is common, participants did not always speak about the practice within a framework of legitimate medical consumption. For instance Sarah often used a prescription painkiller to provide quicker relief from a hangover than an OTC medication may have provided. She recalled one time when she had a bad hangover, saying *"I probably didn't need to take a prescription one but mum had it left over and my friend told me like if you take the Mersyndol Forte then it will get rid of [the hangover] completely"*. This worked well for Sarah as she could get on with her day quicker and get back to domestic work more easily: *"yeah it was good I could just get on with it and I did the washing and took the kids out as well"*.

During an interview with Collin (25), he explored the way experiences of pleasure can complicate medical consumption. When talking about the use of OTC medications after periods of recreational (including licit and

illicit) drug use, he explained that use of Panadol for “a *hangover is not really medical, because it’s something you brought on yourself*”. Collin goes on to explain that analgesic use for headache pain blurs the line between medical and non-medical consumption. He is confident that people can reasonably manage their own use of medication when headache and other pain occurs: “*So if you know you’ve got reasonable pain and you know that what’s gonna help is Panadeine Forte, I’d say that’s taking it for a medical reason*”. Yet this kind of “*self-prescribing*” is also informed by medical notions of ‘proper conduct’ and ‘responsible consumption’:

It’s kind of a tipping point, it’s half medical half recreational. ‘Cause you bought it on yourself, but you are feeling like shit. And if you take a Panadol when you’ve got a hangover you feel better.

Collin described medicine as a kind of omniscient moral arbiter that discourages heavy use of alcohol but is obliged to treat its consequences none-the-less: “*So it’s medical, but the original medical condition is caused by recreational use of something else, like alcohol or whatever*”.

Sean (26) also discussed notions of pleasure in relation to painkiller use for hangovers. As well as the benefits of being able to recover from the hangover, Sean explained that he also enjoyed the physical sensation of the painkiller “*rejuvenating or healing*” his body. When describing the use of painkillers the morning after alcohol use, Sean said:

You'll go out, and you'll be doing breakfast with the people you went out with the night before. Recapping. Debriefing. And someone will be like "hey hey, I've got some Nurofen Plus" or "Panadeine Forte". And you're just like "yes, I'm getting involved in that". Sit around and have it with your coffee and enjoy the slow release of pharmaceutical genius.

The "*pharmaceutical genius*" to which Sean is referring involved both the painkiller's ability to help him recover as well as the pleasurable sensation provided by its analgesic effects.

Accounts of painkiller consumption as "*hangover cure*" (Sarah) demonstrate how cycles of restraint and release are connected. The hangover is a physical state that lies between productivity and pleasure. The use of painkillers to alleviate this state can be part of a desire to return to productivity, to purge the body of the excesses of pleasure, or indeed form a pleasurable experience in-and-of itself.

Conclusion

This chapter has explored contemporary forms of work and play. It has elaborated on how neoliberal discourse has affected changes in modern working conditions, and how painkillers are used to achieve the ideals of flexibility and endurance through uncertainty endorsed by such discourse. A range of empirical examples demonstrate how participants use painkillers to 'bulldoze through' and 'deal with stress' at work, as well as to 'manage

sleep' during busy periods of work. Use of painkillers to improve productive capacity is also extended to less traditional forms of work, such as helping to 'concentrate while studying' and 'taking care of the kids'. The therapeutic capacity of the painkiller is appropriated by individual consumers to preempt discomfort or illness likely to interrupt periods of productive work.

The requirement to be productive is also connected to the way participants engaged in 'time out'. Painkillers are used as a relatively safe and comparatively inexpensive way to 'get more drunk'. Comparisons to the normalisation of illicit drug use are salient, however this kind of consumption relates to broader time-out rituals that are embedded in the 'legitimate' economic and social order. The use of painkillers as a 'hangover cure' is also a key example of how productivity and release are connected. Using painkillers to accelerate recovery from a hangover allows participants to return to productive work sooner than they might otherwise have been able to.

Participants in this chapter describe how the ability to both 'work hard' and 'play hard' can be fostered or enhanced with the use of pain medications. While modern work and recreation have long been mediated by drugs, this chapter has argued that the conditions of late-modernity may permissively encourage individualised negotiations of health and consumer discourse in the pursuit of productive work and recreational release.

The next chapter will also explore the intersections of pleasure and health, this time in the context of chronic pain. It will elaborate on the significance of individual understandings of pain, the stigma attached to the chronic condition and the associations of 'addiction' that haunt its

treatment. The next chapter will explore these themes by providing an in-depth analysis of the lives of three participants who experience chronic pain issues and use pain medications.

Chapter Seven – Chronic pain and dependence

Chronic pain is a debilitating condition that can have a range of serious consequences on the lives of those who experience it. The kind of constant physical suffering experienced by people with chronic pain can interfere with their ability to work or participate in social activities. While an initial injury or condition is often identifiable as the original source of pain, medical knowledge is limited in its capacity to explain why such pain is ongoing (DePalma, Ketchum, & Saullo, 2011). The frustration that accompanies an inability to fully participate in work or social activities, and a lack of knowledge about why, is also likely to be detrimental to the mental and emotional health of those who experience chronic pain (Dow, Roche, & Ziebland, 2012). Epidemiological research has made strong links between chronic pain and the development of clinical forms of depression and anxiety (Gureje, et al., 1998; Bair et al., 2008; Fishbain et al., 1997).

Another important aspect of the experience of chronic pain, which contributes to the emotional difficulties that accompany it, is the stigma associated with both the condition and its treatment. Chapter Four's discussion of medical approaches to pain already established that the chronic pain patient is subject to stigma, including from within the medical profession. At the 2010 Pain Summit a reduction in the stigma associated with chronic pain was named as a priority for the speciality of pain medicine (2010). The treatment of chronic pain often involves the regular use of pharmaceutical opioids (PO). The conflation of regular PO use with illicit

and 'addictive' opiate consumption is an important aspect of the stigmatisation and marginalisation of the chronic pain patient.

This chapter will explore three empirical examples. It begins by discussing the tensions within the medical profession about how to treat pain, which helps to frame the discussion that follows. The chapter then focuses primarily on the lives and experiences of two participants, who will be referred to as 'Allan' and 'Mark', both of whom suffer from chronic physical pain. The chapter discusses how chronic pain has affected their lives, and the way they consume analgesic medications. It addresses the two men's experiences of stigma and discusses their understanding of problematic and dependent painkiller use. Finally the chapter explores the life of a participant named 'Jake', who has experienced chronic emotional pain and who has become dependent on opiates as a result. This chapter explores the way chronic pain affects the lives of those who experience it by providing an in-depth exploration of three different life-histories. Some of the details of the lives of these men have been altered to ensure anonymity.

Treating chronic pain

Before embarking on an exploration of the lives of Allan, Mark and Jake, it is useful to revisit medical approaches to analgesic use for the treatment of chronic pain. Chapter Four has already outlined the way medical approaches to opioid use vary across different medical fields and their associated literatures. Of particular note was the biopsychosocial model endorsed by

the specialty of pain medicine. This approach advocates for a model of care that incorporates clinical observation of the patient's psychological and social well-being alongside more traditional forms of biological assessment. The use of opioid analgesics is still a significant component of the treatment programs recommended under the biopsychosocial model. Advocacy for reducing the stigmatisation of the chronic pain patient is also a notable feature of pain medicine literature (Cohen et al., 2011; Holloway et al., 2007).

There is however a distinct tension between the literature's advocacy for a biopsychosocial approach and the prevalence of more traditional biomedical forms of medical training. The limited capacity for medical practitioners to independently verify a treatable pathology in many chronic pain patients contributes to the stigmatisation of pain patients (Cohen et al., 2011). Sections of the pain medicine literature acknowledge that physicians are often left with a limited framework for understanding pain outside of a biomedical model, and thus can become frustrated with and distrusting of the chronic pain patient (Crowley-Matoka & True, 2012). Reliance on the subjective evaluations of the client's experiences of pain may also cause tension in a relationship typically controlled by the medical professional (Lupton, 2012: 113).

Exchanges about pain interrupt established power differentials between the doctor and the patient by placing the patient's subjective experience of bodily discomfort over the doctor's expertise of the body. In general practice in particular chronic pain is thus often dismissed as either

being psychosomatically produced or not traditionally treatable (Cohen et al., 2011).

Chronic pain patients are particularly vulnerable to stigma if they consume opiates, leading to the medical perception that they already behave like 'drug addicts'. A Norwegian study has noted that, for women in particular, pain patients feel the need to attempt "to fit in with normative, biomedical expectations of correctness" and that it is "hard work behaving as a credible patient" (Werner & Malterud, 2003: 1409). An anthropological study of a US Veterans Affairs clinic has described the ambivalence of medical practitioners towards the pain patient. The study observes that there is a prevalent assumption among physicians that requests for medical prescriptions are equivalent to drug seeking: an article published from the study is aptly titled "No one wants to be the candy man" (Crowley-Matoka & True, 2012). This is also complicated by the heightened political context surrounding the prescription of opiates, for which some US prescribers have even been charged with criminal offences (Reidenberg & Willis, 2007).

This section has developed a series of observations about the treatment of chronic pain within the medical profession. It has outlined how tensions within the medical perspective about how to treat the pain patient and pejorative comparisons to drug dependence inform the stigmatisation of chronic pain. All of these tensions play out in various ways in the lives of three participants who have had very different encounters with chronic pain, stigma and medication consumption. The remainder of the chapter explores the life-histories of Allan, Mark and Jake.

Two patients, two stories

This section will introduce two participants in this study who have experienced chronic pain: Allan and Mark. It provides a brief exploration of how they developed chronic pain and explains the role analgesic and other opiates play in their treatment and beyond. This section introduces these men and their experiences of chronic pain and pain relief before the rest of the chapter explores these issues in more detail.

In 1999, at the age of 32, Allan was a married man and father of a 3-year-old daughter with special needs. The family lived in a small suburban home in north-west Sydney. Allan worked a stable job in traffic control to support the family as well as to pay for the treatment required for his daughter's condition. In early 1999 Allan was involved in a work-place accident that resulted in an injury to his back and ongoing chronic pain: "*I did my back in. Prolapsed disc. But it didn't stop there*" ('Allan' - Interview, May 29, 2012). He was prescribed a range of high dose opioid analgesics to help with the pain.

Months after sustaining the injury Allan was still unable to work: "*I was in pain. It was excruciating. I couldn't do anything*". Allan and the family soon began to consider surgical interventions to help alleviate ongoing chronic pain. After receiving advice from two different specialists it became clear that the surgery, which centred on delicate areas of the lower back and spine, had its risks. Allan agonised over the decision, and even asked the

surgeon *“if it were you, would you do the surgery?”* Allan brought along his father, a pharmacist, for support in the final consultation: *“When it was time to make a decision as to whether or not to have this back operation after the first injury, I took my father with me, who is one of the most clear thinking guys I’ve ever met”*. He was booked in for surgery the very next week.

Three months after the operation Allan returned to work. His job involves co-ordinating traffic lights, message boards and responding to adverse incidents on the road. Allan goes on to say *“my job is just a little bit short of life threatening - I mean we could make mistakes and people might get hurt... and yeah you need to have your faculties about you”*. He recalled that the medications he was being prescribed after the surgery (OxyContin and Endone) sometimes affected his ability to work: *“I reflected a couple of times on just the medication alone prevented me from working”*. This meant that he mostly preferred low dose medications that allowed him to be *“clear-headed”*.

Ongoing pain and continued interruptions to work made his employment more precarious, and in 2001 Allan decided to opt for another surgical intervention. The operation was successful and Allan’s pain was temporarily reduced. However in 2006 Allan experienced a relapse of his injury for which he entered a private hospital for pain management. It was during his time in hospital and just after release that Allan most commonly used prescription opioids: *“straight after the morphine, straight after the operation and then straight after the flare ups again they’ve given me those ones [OxyContin]”*. Allan says that he would move as quickly as possible to lower dose medications because he did not like how it felt being on high

dose opiates: *“just not being able to operate, that was the opiate... the sheer unstraight-headedness that it was causing”*. Still, the prescription medications were essential to getting him back on his feet after relapse.

Six months prior to interview Allan experienced another injury relapse, leaving him only able to work part-time. His wife also fell ill around the same time and his daughter’s doctors indicated that they were concerned about how the pair were going to be able to manage (and afford) her care. Feeling overwhelmed, Allan reflects: *“A couple of problems [have] come at once, which makes care harder, care for our daughter harder, which in turn adds to the stress and then, it’s just a vicious circle isn’t it”*.

Mark is another participant who has experienced problems with chronic pain. His life trajectory however took a different path to that of Allan’s. In 1987 Mark was a working class 25-year-old man who worked as a tradesman. Enjoying the flexibility of not having to work full time for a large company, Mark was mostly employed on short-term contracts. One night in May of 1987, after an uncomfortable evening of disrupted sleep, he was hospitalised for osteomyelitis of the spine. Osteomyelitis is an infection of the bone that is known to be painful (Collert, 1977; Zimmerli, 2010). Mark recalled: *“It debilitates you so you can’t walk. And it works in the spine so its really painful, so I had to have a lot of pain medication”* (‘Mark’ - Interview, 22 August 2012). He remained hospitalised for a period of approximately 6 months, where he was on a regular dose of morphine.

As the osteomyelitis began to improve Mark was released as an outpatient to a team of pain specialists that prescribed OxyContin. After approximately one month the pain team began to taper down Mark’s dose of

OxyContin: *“the pain team they always rely on that, ‘oh well we’ve got to start weening you off the Oxys and put you onto this lower drugs”*. Still experiencing serious pain for months after being released from hospital, Mark became increasingly frustrated by the pain team’s approach. Though his pain had become *“much better”*, it often flared up unexpectedly. The unpredictability of Mark’s pain had a debilitating effect on his ability to work. Without a prescribed dose of appropriate opioids Mark became unwilling to commit to large or long-term contracts.

In order to manage the unpredictable pain and to provide some stability in his work, Mark started to acquire OxyContin from an inner-city *“dealer”* on a regular basis: *“I remember when I legitimately had a lot of pain, they wanted to take me off the painkillers. So I couldn’t sleep or work or anything like that. So I felt like I had no choice”*. By October of 1989 Mark had been taking opiates on an ongoing basis for approximately 16 months, which at this point had mostly been prescribed to him by a physician in relation to his osteomyelitis and ongoing chronic pain. As a result, his level of tolerance was so high that the oral ingestion of PO had little effect anymore. Desperate to be able to work and live without the pain, Mark turned to intravenous and heroin use.

At the time of interview Mark had spent the best part of the previous 25 years living and injecting drugs ‘on the street’. He reflected on his life since his hospitalisation with a deep sense of despair: *“I’m living this illegal sort of underground life-style. I mean how can you esteem yourself? You’re not working. You’ve got no goals. You have nothing stimulating to wake up to*

everyday". The years between Mark's injury and the interview will be explored in the sections that follow.

Living with chronic pain

One important element of the trajectories of the lives of Allan and Mark was the way in which chronic pain has affected their life circumstances. Constant pain and heavy reliance on pain medications produced a range of difficult circumstances that required or initiated changes to their lives. As noted above, Allan's ability to attend work and perform his role effectively has been drastically compromised for significant periods over the last 15 years. Over the years Allan's position at work has become increasingly uncertain and, six months prior to interview he was forced to take on a part-time position. This had a significant negative impact on the family's financial situation.

Impact on work was not however the only way chronic pain affected Allan's life. He is also a life-long volunteer for the State Emergency Service (SES): *"I've been an SES volunteer for 29 and a half years, since I was sixteen. And I love caring for the community"*. Prior to his injury, Allan was heavily involved in volunteer rescue and support operations throughout NSW. An inability to perform the physical tasks required for this kind of involvement meant that Allan's role in the SES was significantly diminished after his injury: *"my ability to carry out most of my function within that organisation [SES] was completely damaged at the same time that I had my operation, or*

my injury". Given the unpredictability of his condition, and the fact that rescue and support operations occasionally involved people whose lives are in danger, Allan decided that he would have to find other ways to be involved in the organisation: *"I've found some other ways to use my skills, I do a lot more training now instead of operating than I used to"*. His role in training at the SES has however been much less satisfying and fulfilling.

Chronic pain also affects Allan's ability to care for his daughter, who has a behavioural disorder. Aside from his capacity to work, and thus finance various treatments, pain also limits Allan's ability to, for instance, help his daughter get dressed in the morning or get her to the doctor: *"sometimes I just kind of feel useless, and that can be really stressful"*. At the time of interview Allan's daughter had been hospitalised for six weeks, and a recent flare up meant he was not able to visit as often as he would like.

Discussion about care for his daughter also sparked reflection on the connection between stress and health: *"I think the body is so intertwined. How injury can cause stress and how stress can cause injury"*. He described an intimate relationship between the stresses associated with the deteriorating health of his wife and daughter and his own health:

My wife and I are very conscious that my daughter's problems have been at their worse for the last three years, and just in the last year or so my wife's health hasn't been well either. Were the doctors used to say "be careful of your health because, if you deteriorate, your care deteriorates". That's sort of come to pass now.

Allan goes on to explain that his most recent flare up may have had a lot to do with stress about the family's health:

Because my back went twice, [in the past] I could pinpoint the injury. Whereas this time I hadn't had any [physical activity] - I wasn't in the cubical trying on clothes and got up the wrong way. I've got nothing to point to this time... That's one thing that's freaked me out, that perhaps my flare up this time was more to do with [worrying about] my daughter than [my] actual injury.

Beyond the physical debilitation of chronic pain, stress forms a significant element of the way chronic pain affects Allan's life, his ability to work and care for his family. Allan's observations about the relationship between stress and physical health are salient examples of why the biopsychosocial has emerged in medical discourse.

For Mark, living with chronic pain is inseparable from the use of pain medications. Mark explains that, after his injury he spent a long time in hospital and opiate use was a mundane part of that experience. After leaving the hospital Mark's pain team provided instructions about how and when to use his medications. He goes on to explain that even when not prescribed to him directly, for many years his use of OxyContin was in line with the instructions that physicians had provided: *"I was just doing what the doctors had told me to do"*.

As Mark began to obtain OxyContin from street-based drug markets the pain team became increasingly suspicious of how he was acquiring his

medications and eventually stopped prescribing them altogether. His pain specialist moved him onto a lower dose OTC analgesics such as Panadeine and Nurofen that did not satisfactorily cover the pain: *“but I was still in pain, I still needed to work, so I had to continue using [opiates]”*. Not knowing when the pain would return, and not having access to an appropriate dose of analgesic to manage it, made contractual commitments to physical labour difficult. This was the primary reason for Mark’s initial use of heroin. On the recommendation of a long-term friend who had been helping him acquire OxyContin, Mark decided to inject heroin to properly ameliorate the pain of a particularly nasty flare up while in the middle of an important job.

Within the context of persistent physical pain that was producing instability in his employment, Mark decided to manage the situation as best he knew how: *“So I was forced, through the pain, to go and get the drugs off the street”*. For approximately 6 months following this initial injection of heroin Mark used both OxyContin and heroin intravenously on an intermittent basis: *“[at the start] it didn’t really affect my life as much as you might think”*. However, as Mark became more and more immersed in the street culture of Kings Cross, where he *“scored”* (acquired) and *“banged up”* (injected) most of his drugs, intravenous consumption began to gather some pleasurable and emotional significance. Opiate injection became a respite from the pain, a kind of relief that had been rare since leaving hospital a few years earlier.

Using opiates and other analgesics

Allan and Mark had different responses to and experiences with their medications. While Allan felt that, on balance, lower dose medication provided a better outcome, Mark regarded OTC analgesics to be entirely ineffective in reducing his pain. This section will elaborate on the two men's personal experiences using opiates and other analgesics. It explores the way analgesic medications form part of life routines and canvasses the meanings that have become attached to such consumption in their lives.

Allan's use of painkillers was largely restricted to OTC analgesics, except during periods of unexpected flare up or relapse. His use of Panadeine is the most regular of all the medications he has used since the injury. Allan does not like using prescription opiates (OxyContin and Endone) and he limits their use to times when his pain is otherwise unbearable: *"they're about the only times I've used it, is straight after the morphine, straight after the operation and then straight after the flare ups again they've given me those ones. Yeah no literally the strongest thing I take is Panadeine Forte"*. One of the main reasons for this is that Allan is unable to concentrate when using OxyContin in particular. This is particularly problematic when at work, dealing with potential injuries on the road: *"it's just a realisation that you know you probably could cause something to happen bad if you did try and work with that sort of level of non-clear-headedness"*.

Still, Allan says that the use of pain medications, including OxyContin, is a vital part of his ability to perform everyday functions:

at the end of the day I would be worse if I wasn't taking what I'm taking when I'm taking it. And to a certain degree I've got to be - it's the only way to really manage my day-to-day affairs when I'm at my worse.

Allan describes a complex relationship between his pain and prescription medications. While PO were selectively useful in getting Allan back on his feet after a flare up, they could be equally problematic by impairing his ability to think clearly.

For Mark opiate use had different kinds of significance at different times in his life. For the first two years after his initial hospitalisation, Mark was simply using opiates at the direction of his doctors. Opiates were a common part of his treatment: *"it felt like they gave them to me almost every day"*. However, as the pain team tapered down Mark's dose and he began to obtain his OxyContin via illicit means, acquiring the medication and using it became a necessary routine in order to stay in work: *"I was always trying to find more, just in case"*. Once he transitioned to intravenous use of OxyContin pleasure began to enter in the equation. After a year of intravenous use the line between pain relief and pleasurable inebriation had become indistinct for Mark: *"cause I was in pain but I also liked the way it made me feel"*.

Mark spoke in detail about the euphoric feeling that opiates provided. He explains, *"they give you a really good feeling inside. They're a good relaxant. There's no side-effects psychologically. You know, you don't have any hallucinations or anything like that. You just feel a tremendous peace and a*

warmth". In a vivid description of the way he feels when using opiates Mark compares the physical sensation to the Christian notion of the Holy Spirit:

From a spiritual perspective, a lot of people have felt the Holy Spirit. And in their testimony in church they've said they felt a beautiful warmth come upon me. Well I liken the euphoric effect of painkillers to it being a FALSE Holy Spirit, 'cause it feels like the Holy Spirit.

This feeling of a "beautiful warmth" is described as particularly appealing, and an important part of the reason why Mark continues to use opiates: "that's why it's so desirable, why people want to experience it again and again and again. It becomes better than an orgasm you know".

Mark has also used heroin – or 'gear' – interchangeably with PO over the last 20 years. While PO and heroin are described as "pretty similar really", Mark does emphasise the benefits of injecting prescribed opiates. He explains that: "With the Oxys [OxyContin tablets] you're guaranteed that you know what you're getting. And it's very strong, 'cause it's legal. With the gear, it's Russian roulette. You don't know what you're getting". While PO are regarded as safer and more ideal, sometimes heroin is all that is available: "sometimes there's no Oxy on the street and so you go for the gear instead". Occasionally Mark even prefers to inject heroin instead of OxyContin: "Just for a change. [If] I was told there was really good gear on the street. Really potent, really strong".

The pain relieving and pleasurable aspects of Mark's opiate use are also tied to the consequences of stigma associated with his dependence.

Stigma had significant impact on how Mark felt about himself and thus his experiences of emotional pain, which he subsequently self-medicated with opiate use. Allan experienced stigma of a different kind, more closely associated with his chronic pain condition and how he used medications to treat it. The next section will discuss Allan and Mark's experiences of stigma and how they have dealt with it over the years.

Dealing with stigma

Dealing with stigma was an important part of Allan and Mark's experiences of chronic pain and opiate use. The conditions they suffer from and the way they use analgesics to manage various forms of pain were a constant source of stigma. Sociological accounts of stigma indicate that the concept is a manifestation of social disapproval of traits or behaviours that society deems to be outside the 'norm' (Goffman, 1963). The way people experiencing stigma and internalise pronouncements of 'shame' has also been a key features of the sociology of stigma, particularly as it relates to chronic health conditions (Steward et al., 2008). The inability to objectively/medically verify pain and the often-ambiguous source of its chronic relapse inform its disapproval, weather consciously by a health care professionals or structurally through the system in which they operate. Moreover, the moral weight attached to dependent and illicit consumption produces a range of marginalising consequences for those experiencing or

deemed to engaged in such consumption. Both Allan and Mark reflected on how such social disapproval has impacted the way they live their lives.

Allan says that stigma often surrounds his inability to do basic everyday tasks properly when he is in pain. He explains that his family often do not understand how the pain affects his ability to function and do basic tasks:

I even have trouble convincing my own family, my own wife that I'm in pain or I've got a problem or I need some help. So for example if I ask her if you wouldn't mind making me a cuppa there's probably a reason, but she'll just roll her eyes.

Part of the problem is that his injury is not visible. Allan reflects that:

my injury, my disability is very much an unseen - it's not a broken leg, I haven't got plaster on my arm... I just wish sometimes that I had a cast on my leg or my arm because people would know what we go through.

His use of medications also adds to the stigma:

if I take that [box of medication] out and put it on my desk at work, which is my one day's medication type thing, morning, lunch, evening and night... if people see that at work and either think, one, "you're a hypochondriac" or a - we often joke about how I keep the drug

companies going because it's just my use alone. Yeah no there's an ostracisation I believe just in that alone.

Allan expresses concern about what kind of impression his use of medications leaves on his co-workers. He wonders if they think “*is he a druggie because he's got all that?*” or “*is he any less of a worker because he's on that sort of a medication?*” Allan mostly tries to brush off these concerns with humour: “*I often joke about how I've got uppers and downers, and that ones to go with that ones *haha**”.

Stigma and marginalisation have also played an important role in Mark's life over the last 25 years. Mark explains that the assumption that he is ‘drug seeking’ has eroded his relationship with the medical profession and those who have treated his chronic pain: “*as soon as they get it into their minds that you are abusing them they just stop caring, stop treating you properly*”. He goes on to explain that, after feeling abandoned by his doctors and developing a regular pattern of opiate injection, the stigma of intravenous use affected all of the relationships in his life: “*I'm ostracised from my family. I have no meaningful relationship with anybody*”. This kind of marginalisation also has a detrimental impact of Mark's sense of self-worth:

It's not just the painkillers, it's all the social problems that it brings. You know unemployment. And especially how it impacts on your confidence and self-esteem and how you feel about yourself. You know even though you can support your addiction and everything, it's nothing to be proud of. It just eats away at you.

In Mark's case the assumption of 'drug seeking', and the stigma associated with it, is implicated in his eventual development of problematic patterns of opiate use that have had a devastating impact on his life.

Mark felt a deep sense of suffering at the injustice of this stigma, even describing it as a form of pain: "*The torment that you go through from being addicted to painkillers and the tricks you have to do to sustain it... so you feel a lot of mental pain when that happens*". He goes on to explain that the only way he now has to escape the stigma and its impact on his life is to go to sleep. However, not having had stable housing for the past 10 years makes sleep an uncertainty. Part of the reason why he continues to inject PO and heroin is to help him get to sleep wherever and whenever he can: "*I mean I actually enjoy going to sleep, when I can. It's like a bit of a relief or release from the consciousness of the hell that I'm in. It turns it off. I escape just by being asleep*". The next section will deal in more detail with the impact that 'addiction' has had on Mark's life.

For both Allan and Mark the stigma of chronic pain and drug use has had significant impacts of their lives. One important element of the stigma that surrounds chronic pain and analgesic use is its relationship to substance use and drug dependence. Concerns about the nature and definition of problematic and dependent consumption in the lives of Allan and Mark will be the subject of the next section.

Problematic and dependent consumption?

Throughout conversation with Allan and Mark concern about problematic and dependent consumption was often raised. Allan spoke about concerns regarding the way he used his medications, though he was reluctant to describe these as 'addictive' behaviour. While Mark raised a range of concerns about the use of pain medication, which he often directly referred to as part of an 'addiction'. This section will outline the differences and similarities between the way the two men define and experience problematic or dependent consumption of pain medications.

At the time of interview Allan had been using pain medications "*pretty long-term and pretty seriously over the last 14 odd years*". This meant that Allan had had a long time to think about the complexity of how and why he uses pain medications. Allan remarks that: "*I've reflected to myself whether or not I should be taking a certain level of drugs or whether you get yourself into a false sense of, 'if I take this painkillers, is it going to prevent pain later or not'*". Allan says that he often wonders whether his use is, what he refers to as "*proactive or reactive*". He goes on to explain that reactive use is in response to pain, and can thus be considered more legitimate: "*you know within yourself that if you're hurting you take a Panadol and if you're hurting more you might need a Panadeine*". The use of painkillers in response to pain was juxtaposed to the use of painkillers in anticipation of pain: Allan's 'proactive use'.

Allan engaged in proactive use to avoid the emergence of pain in order to make sure he could get a good night's sleep, or be able to function at

work. He explains that he often takes painkillers before he goes to bed, whether in pain or not. This ensures that Allan will be able to sleep without worrying: *"The nights I forget to or don't take it [Panadol], I know the night's not going to be as good. I'll have more broken sleep"*. He also uses painkillers most days before work, so that he can avoid the possibility of a painful flare up: *"sometimes I know its gonna be a busy day and I just take them before the pain starts"*.

Part of Allan's dilemma revolves around the idea that, while outside of the convention of his medical treatment, proactive use often makes his life much easier. Allan wonders how often he uses painkillers to allow for better sleep or to make his work bearable, rather than to more directly relieve pain. This also extends to his family life: *"I'm in a better position to deal with family life and home if I'm not quite in pain. I think I might function a bit better"*. The ability to avoid pain, or to eliminate the possibility of it affecting his day is a significant part of how Allan now uses his pain medications: *"I'm sure that I operate better when I'm not in pain... and when I take a Panadol I don't have to worry about it"*. It is however this kind of painkiller use that stirs concern about the propriety of his consumption: *"am I doing the wrong thing by using them proactively?"*

Concern about whether proactive use is the *"wrong way to use painkillers"* also prompted comparisons to recreational and dependent consumption. While recalling one time at work when Allan had used a prescription painkiller proactively he said: *"It was quite a funky feeling obviously, I take it that that must be what recreational drug use would give you"*. He was also quick to note *"I've never used a recreational drug in my*

life". When explaining that he uses painkillers almost every day, and that he has been doing so for years Allan despairs that:

You hear the saying that too much medication and for too long can be not good for your health and I always try to think how to reduce the amount. But to a certain degree with my disability it'll never - I'll never be tablet free again.

While his descriptions above imply a significant dependence on pain medications to function without pain, Allan went on to quickly dispel any implication that he was 'addicted': *"I don't class myself as being addicted to any form of medication"*.

For Allan proactive use is aimed at making his day more efficient and easier to manage, yet concern about the appropriateness of his consumption illustrates how addiction discourse can encroach on practices of consumption. While Allan expressed concern about the 'wrong' way to use painkillers and a dependence on them to function without pain, a framework of 'addiction' was still excluded from his experience. For Allan, ongoing pain and the use of low dose analgesics provide a legitimising framework that is not compatible with notions of 'addiction': *"I don't believe one five milligram tablet of paracetamol per day, neither does my doctor believe, that there is anything to be worried about"*.

Unlike Allan, Mark often referred to his painkiller use as part of an 'addiction': he describes himself as being 'addicted' to pain medications and refers to himself as an 'addict'. Importantly however, it is not just the

regular consumption of painkillers that defines addiction for Mark. Participation in illegal activity and the social marginalisation that accompanies it were central to the way Mark experiences addiction. For instance, in order to maintain a level of financial stability, and to sustain his drug use, Mark sells drugs on a regular basis. Part way through the interview Mark fielded a call from a young woman who was looking to acquire ecstasy pills for the weekend. After finishing the call Mark said *“This is what keeps me afloat. You haven’t got many other options when you’re an addict”*.

The way Mark acquires his medications is also significant to note. While Mark buys a portion of his OxyContin from the illicit drug market, he also acquires a range of prescriptions from different physicians: *“I’ve got five doctors I go and see. Yeah well because of my history [with osteomyelitis] and everything I’ve got all of the documentation”*. Mark is also sure to remain abreast of policy developments and how they might impact his ability to acquire opioids. When referring to policy discussion surrounding the electronic monitoring of pharmaceutical purchases, Mark says he has already prepared for its introduction by learning how to alter identification cards: *“It’s very easy to go to an internet cafe and change the names and everything”*. These forms of deceptive and criminal behaviour are an important part of how Mark constitutes his experience as an ‘addict’:

So they put all these little hurdles before us. But because the addiction is so strong, it’s so powerful, you can get over it, get around it. But really

it's just another trick of a lot of tricks you have to do when you're an addict.

It is not simply the regular use of pain medications that constitutes Mark's addiction. Despite regular use of prescription opiates when in hospital and just following his release from hospital, Mark rarely referred to himself as an 'addict' during this time. However, his descriptions of the political economy of criminal activity required to sustain his drug use were replete with references to addiction.

Reflecting on his dependence and the way in which it required involvement with crime, Mark explained that he felt abandoned by the medical practitioners charged with his care. After his original hospitalisation, medical staff prescribed him opiates for a period of 18 months. Once Mark was dependent on the medication, it was taken away and he was left in circumstances he felt unequipped to deal with: *"This all started... [from] being in hospital. And it's just been hell ever since. 'Cause it's a trap. You're in a trap you can't get out of"*. While Mark acknowledges that chronic pain is not the only reason why he continues to use opiates, he defends against the stigma of a *"crazy drug fiend"* that he is often subject to:

Initially I didn't voluntarily go out and use drugs for leisure or anything... I was on morphine, they prescribed me morphine because of osteomyelitis in the spine. And by the time I left the hospital I was hooked, I was dependent on the morphine. Part of the pain team management was Oxy, and that's how I got hooked on them.

He is also highly critical of the way the medical profession has deal with his substance use: *"A lot of people say that people who are addicted are sick. You know it's an illness... so they should want to help you, but they just don't give a fuck"*. In Mark's case it is important to recognise that he did not have a previous medical history of substance use, and that his medical care (or lack of it) is in fact a central turning point in his development of problematic consumption and 'addictive' behaviours.

Despite Mark's conviction that most of the circumstances of his 'addiction' are outside his control, the stigma associated with it has still had debilitating effects on the conditions of his life. When describing the impact drug dependence has had on his life Mark reflects: *"It's just destroyed my life"*. Living under the uncertain and criminalised conditions that characterise cultures of IDU for more than 20 years has taken its toll on Mark:

I've been addicted to them for years. Everything is focussed on getting them, using them. And everything suffers. Relationships with family and friends. Especially relationships with yourself.

Mark's sense of self has been eroded by having to *"hustle for the basics"* for so long. Moreover, this lack of self-confidence is solidified by structural marginalisation: *"I've got no education in order to get a decent job. So I've no access to credit or anything that can help to give sort of quality of lifestyle"*. Mark is bleak and defeated as he reflects: *"using painkillers and addiction, it*

takes away all hope. So if you have no hope there's not much to look forward to at all".

Chronic emotional pain?

It is clear from the examples discussed thus far that chronic physical pain brings with it changing life-circumstances and forms of social stigma that are emotionally difficult. Allan felt ostracised from his work and family life, and a sense of loss at not being able to participate in the SES and take care of his wife and daughter. Similarly, Mark felt betrayed by medical practitioners charged with his care. This was related to other forms of suffering as he was forced to live 'on the street' and engage in criminal activity. Allan and Mark's lives are salient examples of the significance of the emotional elements of pain. From these experiences a series of related questions about emotional pain unrelated to physical injury also emerge as noteworthy. The remainder of this section explores the life of a third participant who has encountered prolonged periods of emotional pain and has been using painkillers to alleviate it.

Jake was born in 1983, and was 29 at the time of interview. His family home is in the culturally diverse, though largely disadvantaged suburb of Campbelltown in south-west Sydney. In 2000, at the age of 17, Jake was introduced to a young woman named 'Louise' through mutual friends. The pair fell in love hard and fast. After four years with Louise she became the victim of a violent assault, which, after a short period of hospitalisation,

resulted in her death. Though the crime had occurred almost a decade before the interview, it still commands a great deal of Jake's emotional energy. Jake was unable to sleep for months after Louise's murder and he visited a range of community health services which "*were basically shit and didn't help at all*" ('Jake' - Interview, October 8, 2012).

Jake was first introduced to OxyContin by a friend a few months after Louise's death: "*I started using them to block that out because I couldn't sleep at night and a friend put me onto them and I was trying all sorts of other drugs just to knock myself out*". During this time Jake also experimented with cocaine, amphetamines and benzodiazepines, among other drugs, to try and help cope with the loss.

Over a period of approximately 6 months OxyContin began to emerge as Jake's drug of choice. For a time OxyContin seemed to allow Jake some respite from the difficult emotions associated with the death of his girlfriend, and he gradually started to use the medication more frequently:

I started out using maybe one pill a fortnight and I went to a pill a week and it got worse and started being nearly every day and eventually probably after about twelve months or so using got really addicted to them and couldn't basically start the day without one.

After appropriately 18 months Jake began to notice that his use of OxyContin was becoming a problem, and he entered a local rehabilitation programme in early 2007. He had a mixed response to his experience in the facility, but noted that "*at least I got off them for a while*".

Still struggling with feelings of loneliness Jake return to occasional oral OxyContin use in May of 2007, but found that long periods of regular oral ingestion had rendered his tolerance high enough not to feel the effects very much anymore. In April of 2008 a friend who had been supplying Jake with OxyContin recommended that he try injecting methadone to “*get a good night’s sleep*”. Jake recalled “*I liked the feeling, the experience I had on it [methadone]*”. Encouraged by the “*relaxing effect*”, Jake’s initial intravenous use of methadone was followed rapidly by a spate of intravenous heroin use:

after a few weeks of using that I couldn’t get methadone anymore so I got introduced to a heroin dealer and started using heroin and at the time I was using out in Campbelltown way, [eventually even] doing it at home with parents and my little sister in the next room.

After discovering drug paraphernalia in the house, Jake’s parents removed him from the family home and he moved to the inner city in early 2008: “*I ended up in Kings Cross and with no heroin around or anything and I was staying in a homeless refuge*”.

With limited knowledge of the local drug scene, heroin became difficult to acquire and someone he met at the shelter offered him OxyContin, which Jake had never injected before: “*I didn’t know what to do with it so they mixed it up and shot me up*”. Jake explains that it was during this time that he developed a great deal of flexibility in his drug consumption. He would use whatever was “*cheaper*” and “*easier to get*”. Jake continued to inject an assortment of pharmaceutical and illicit opiates for

the majority of the period between 2008 and 2010. During this time he moved between home detention stepping from a conviction related to a string of burglaries he was involved with, homelessness and a series of unstable housing arrangements, while making several attempts at detoxification and using a range of harm minimisation services such as NSP, Sydney's MSIC, and OST. In late-2010 Jake was stabilised on methadone for a period of approximately two years. He reported first injecting his (prescribed) methadone two months prior to interview, which was followed a week later by a return to intravenous heroin use.

Jake had particular expectations about the ability of a pharmaceutical like OxyContin to numb his pain, and for a time the medication did fulfil those expectations. He slept better and was able to get on with his life. However those benefits did not last. After participating in a detoxification program for the first time in 2007 Jake observed a series of shifts in the forms of social support available to him. His friends and family, along with any medical practitioners that found out about his drug use, became constantly sceptical of Jake. He became reluctant to visit the doctor and was eventually asked to leave the family home. These conditions were only exacerbated by difficult feelings of loneliness, for which Jake was using opiates to alleviate.

Once Jake was living on the street a lack of financial security and uncertain housing arrangements resulted in a form of entrenched loneliness. Jake explains that, during periods of prolonged intravenous use, it is the need to avoid withdrawal that sustains his consumption of opiates:

I'm just physically addicted to them. Generally don't want to take them and when I do take it I feel like I need to and I don't feel any better until I have taken it. I don't mentally – I don't want it if that makes much sense.

However, Jake goes on to explain that recurring feelings of loneliness often thwart any attempt to remain opiate free:

but then I detox [and] I'll be fine for a bit, I'll get clean off them again and they send me home and I'm right for a couple of weeks. But like after a while I get lonely and I always go back to them, like I don't know what else to do when I feel like that.

The reliability of the physical sensation that painkillers provide is one way in which Jake manages the uncertain conditions that characterise cultures of street-based IDU. He explains that: *“if I'm in pain I want to stop it as quickly and easily as possible. That means going and seeing a doctor and getting medication or buying morphine off the street, whatever. I'll do whatever it takes not to be in pain”*.

Problematizing Pain

Thus far this chapter has outlined the lives of three men who have experienced different kinds of pain, and had different experiences with painkillers to alleviate that pain. This section will compare the kinds of pain

they suffer and the way it has affected their lives. In summarising and comparing these men's experiences of pain, this section will also problematise the way physical pain is often separated from emotional pain in general medical discourse and practice.

After a workplace accident in 1999, ongoing physical pain has consistently compromised Allan's capacity to work both in his job and as a volunteer for the SES. His condition has also made care for his daughter more difficult. Alongside the disability of physical pain, Allan explains that the stigma associated with his condition and its treatment is difficult to escape. This stigma has had significant impact on the way Allan himself understands his own medication consumption. Allan is reflective in his observation about the use of analgesics to pre-empt pain, presenting a set of concerns about whether he is using them the 'wrong way'. Allan elaborates on concerns that he is dependent on pain medications to operate without pain, and that is often a source of stress that can inflame physical pain. This even leads Allan to make tentative comparisons to illicit and addictive consumption.

Mark's descriptions of chronic pain are dominated by the way he subsequently developed an 'addiction' as a result of its treatment. The pain associated with osteomyelitis of the spine made it difficult for Mark to participate in physical labour. In order to keep in work Mark began to acquire painkillers and eventually heroin from street-based illicit drug markets. More than twenty five years after his initial hospitalisation Mark now uses painkillers for a complex set of reasons: such as to relieve physical pain and "*make it bearable*"; to stave off withdrawal with a product that is

“guaranteed on the quality”; to get a euphoric feeling that is *“better than an orgasm”*; and to alleviate the emotional difficulties of *“having to live this illegal sort of underground lifestyle”*. Mark’s example highlights the role and responsibility of the medical profession in caring for people with chronic pain, and the impact that subsequent treatments may have on the lives of patients.

Finally, Jake’s example brings into focus a less recognised form of chronic pain. As Jake’s story demonstrates, constant emotional suffering can be just as debilitating as persistent physical pain. Indeed there are many overlaps between Jake’s experience of chronic emotional suffering and Allan and Mark’s chronic physical pain. Like Allan, pain affected Jake’s ability to sleep: painkillers helped Jake forget about Louise’s death so that he could ease into sleep. Jake’s use of pain medications also affected his life circumstances, eventually informing stigma from family and medical professionals. As was the case for Mark, Jake also felt unable to rely on the medical profession to help him through his pain and subsequent drug dependence. Moreover, Jake’s need to avoid the pain of physical withdrawal cannot be separated from the forms of emotional distress that accompany Jake’s sense of loss and loneliness.

Mark and Jake’s accounts include noteworthy detail about the role of medicine in their dependence on opiates. They describe feeling alienated from treatment services and medical professionals when the issue of substance use became part of how they dealt with the chronic conditions they were experiencing. While Allan’s experiences of stigmatisation are significant, they do not appear to come directly from medical practitioners

and thus seem to have less of an impact on his medical care. This has salient links with sociological observations about the way pain medicine has reformulated addiction in ways that rely on moral assumptions about what pain is and who deserves (opioid) treatment for it. In such accounts, the pain of the 'addict' is constantly delegitimised (Bell & Salmon, 2009).

The examples in this chapter demonstrate that people's experience of physical pain, social suffering and emotional anguish can be fluid and interrelated. Chronic pain, whether physical or emotional, is debilitating and thus often means that those who experience it must rely on external structures (such as familial and social support) for their lives to operate smoothly. Medicine is also one of those important structures – providing access to painkillers is the culturally accepted norm for medicine to fulfil its responsibility to alleviate human suffering. However, especially when drug dependence enters the equation, traditional forms of support for those experiencing chronic pain become unreliable and people are often left to fend for themselves – the results can be tragic.

Conclusion

This chapter has explored the way chronic pain and dependence intersects in the lives of three participants. Allan and Mark's examples demonstrate how persistent physical pain can transform people's lives: this involves practical considerations as a result of physical injury, but also the impact of forms of social stigma. Jake's example introduced a less recognised form of

chronic emotional pain and highlighted the similarities it has with the impacts of physical pain. One of the key elements of the narratives provided by Allan, Mark and Jake is the way chronic pain affects their ability to be productive, or even participate in productive society.

The theme of participation in productivity society has noteworthy links to the previous chapter, which focussed on the way pain medications are used to increase or sustain productivity at work. Much like the participants in Chapter Five, pleasure also became part of all three men's use of painkillers – albeit in varying degrees. It is important to note that for the participants in this chapter pain relief and pleasure were inseparable experiences: Allan compares the use of PO during a flare up of pain to recreational drug use; Mark derives pleasure from release from intense physical and pervasive emotional pain; Jake began to enjoy the respite from feelings of emotional loss and a deep sense of loneliness when using PO.

The next chapter engages the notion of 'addiction' more directly by providing a sociological critique of its ability to explain drug use in the lives of two participants. It explores the life histories of two participants who no longer use drugs. The lives of 'Emma' and 'Felix' are explored for the clues they provide in order to think about drug use outside of the framework of 'addiction'.

Chapter Eight – Beyond ‘addiction’

Of the various concerns about non-medical consumption, a transition to intravenous use and ‘addiction’ is the most pronounced in media and health discourse. A 2014 article in the *Daily Telegraph* reports that “The most desired drugs – which addicts and dealers distil and inject – are the opioid pills MS Contin and OxyContin”. In an investigative piece on the *ABC Four Corners* program, reporter Matthew Carney warns that the “misuse of powerful prescription drugs is creating a new generation of addicts” and a physician interviewed for the program observes that “on the whole, most of these people are indistinguishable - they’re not your typical addicts” (2010). Media reporting is particularly focussed on a narrative of transition from ‘everyday’ to ‘transgressive’ and from ‘normal person’ to ‘drug addict’.

This kind of commentary is emblematic of heightened media reporting about the dangers and vices of unbridled opioid use. However, as we have seen throughout Part Two of the thesis thus far, this is hardly a representative account of non-medical consumption. For the young people discussed in Chapter Five painkillers are a consciously chosen alternative to illicit drugs, or are an ideal complement to other forms of recreational drug use. Far from the stereotype of spiralling out of control, these young people carefully negotiate the illicit context of their drug use by introducing licit or pharmaceutical substances. For the participants in Chapter Six, intravenous use and criminal activity did not feature in their experience with non-

medical consumption. In fact the use of painkillers was seen as a way to enhance the legitimate pursuits of productive work and recreational release.

Chapter Seven addressed the issue of drug dependence more directly, focussing on the link between chronic pain and prolonged opioid use. For Allan, Mark and Jake (from the previous chapter) the debilitating effects of chronic pain necessarily inform their continued use of opioid medications. This has important links to the historical and conceptual developments of addiction discussed in Part One of the thesis. The study of addiction incorporates moralising distinctions based on social structures such as race and class. For instance, middle class housewives and doctors during the middle of last century in North America were thought of as 'normal people' who had become addicted 'accidentally' – through medical treatment (Acker, 2002). In contrast, impoverished young black men were regarded as 'psychopaths' whose addiction was the result of 'hedonism'. Throughout the remainder of the century these moral distinctions were formalised in medical models of addiction through an emphasis on the physiological and psychological elements of the emerging 'brain disease of addiction'.

This chapter will address the limitations of addiction as a framework for understanding the use of opioids, by focusing on the life-histories of two people who no longer use drugs: 'Emma' and 'Felix'. It begins with a review of sociological accounts of addiction before introducing the detailed life histories of Emma and Felix. The chapter then moves on to address the epidemiological literature's focus on transitions from 'soft' – or licit – to 'hard' – or illicit – drugs as a key concern about non-medical consumption.

The chapter also addresses the notion of 'loss of control' by critically engaging with the research literature about agency in IDU.

The sociology of addiction

Until recently the social sciences had been reluctant to engage with the concept of 'addiction'. Two central concerns underpin sociology's lack of interest in addiction: the first is the way addiction is embedded in therapeutic frameworks that belie the sociological tendency to problematise the medical designation of social problems (Weinberg, 2011); the second is to avoid reproducing the moralising discourses that characterise 'out of control' consumption as a betrayal of the modernist value of restraint (Lenson, 1999). These are important critiques that need to be taken seriously in any sociological engagement with addiction. However, even given such hesitations many sociologists have come to recognise that empirical evidence does suggest that a small minority of people who use drugs describe and demonstrate a sense of 'loss of control', and that this cannot simply be explained as being imposed by agents of social control. This section will canvas a set of literature that has come to be termed the sociology of addiction.

Despite being somewhat less developed than the sociological literature on drug use and drug cultures, there have been important sociological studies that have directly addressed 'addiction'. One of the first, and certainly the most influential sociological studies of addiction was Alfred

Lindesmith's (1938) study of heroin users. Based on interviews with approximately fifty "heroin addicts" Lindesmith developed a theoretical account of addiction, arguing that a conscious recognition of the use of opiates to stave off withdrawal defined the 'addict':

Any satisfactory theory must attempt to account for the fact that the repeated administration of opiates sometimes is followed by addiction and sometimes is not. The factor which accounts for this differential effect appears to be the person's knowledge or belief, supplied him [sic] by his cultural milieu, concerning the nature of the distress that accompanies the sudden cessation of the opiate. If he fails to realize the connection between this distress and the opiate he escapes addiction, whereas if he attributes the discomfort to the opiate and thereafter uses the opiate to alleviate it he invariably becomes addicted. (1938: 593)

For Lindensmith addiction was a social process by which people who use drugs only became an 'addict' when reflecting back the cultural stereotype by consciously using opiates to 'stave off withdrawal'.

The lasting impact of Lindesmith's contribution lies in its demonstration that people have meaningful responses to drug use that cannot be reduced to its pharmacological effects on the body (Weinberg, 1997). A range of functionalist contributions during the 1960s extended Lindesmith's theory by describing addiction as a rationally calculated response to social-structural disadvantage (Ray, Cloward & Ohlin, 1960;

1961). These kinds of functionalist accounts tended however to be largely conservative and thus conceived of addiction as a deviance that required 'correction' (Weinberg, 2011: 301).

As part of a broader rejection of functionalist sociology during the second half of the twentieth century, qualitative traditions of the sociology of deviance entered, what Matza (1969) calls an 'appreciative' turn in drug research. Qualitative drugs research from the 1960s onwards has attempted to empathise with those labelled 'deviants' and especially 'addicts'. During the height of its influence in the 1970s labelling perspectives in sociology and criminology tended to present addiction as an internalised identity imposed by agents of social control. Sociologists of deviance thus often engaged people who describe themselves as 'addicts', yet only ever addressed addiction in ambiguous ways that reduced it to a label.

Denzin (1987) was one of the only labelling theorists to treat addiction as worthy of genuine sociological study. In his work on alcoholism the 'emotionally divided self' played an important role in his theorisation of addiction. Denzin contended that alcoholics were internally conflicted about their consumption of alcohol, and that this internal conflict was reflective of broader social conditions that both encourage its consumption and reject its overconsumption. In this account compulsive alcohol use is presented as part of a social context that produces the particular conditions under which 'addiction' to alcohol emerges.

Social constructionist perspectives have also extended Denzin's theorisation of addiction. Social constructionists have argued that the practices that make up 'addiction' are necessarily embedded in the

conditions of late-modernity. That is to say, not only does 'addiction' have social determinants but it is "unintelligible outside the nexus of cultural practices and beliefs within which it is found" (Weinberg, 2011: 304). For instance Levine (1978) argued that the Temperance movements of the early twentieth century produced demands about self-control and an accountability to economic responsibility, for which the pathology of 'alcoholism' emerged as an answer. Acker (2002) argues that a series of social and political movements in North America collectively constituted "the classical era of narcotic control", which subsequently produces the concept of and the practices that comprise the urban 'junkie'.

The work of Keane also makes important contributions to the social constructionist perspective through a poststructuralist analysis of discourse, and its role in assembling the various elements of addiction discourse into a stable biomedical entity. Keane's analysis of addiction discourse has highlighted its expansion to other forms of strong attachments and habitual practices that are not limited to drug use (such as gambling, exercise, sex, food, etc) (Fraser et al., 2014; Keane, 2002). This can be partly explained by changes to the way 'addiction' is formulated in contemporary medicine, with medical discourse constantly expanding the reach of what is 'addictive' and what it means to be 'addicted'. This has also contributed to, what Sedwick (1993) refers to as an epidemic of "addiction attribution", in which there has been a proliferation of human behaviours deemed to be addictive: some recent examples include "workaholism," 'shopaholism,' 'being sexual compulsive,' 'relationship addiction,' 'exercise

addiction,' and the all too self-aware 'self-help addiction'" (O'Toole & Connect, 2013: 25).

A sociological approach to addiction requires a problematisation of medical accounts of addiction that present it to be a stable or fixed disease state. The sociological perspective thus complicates the linear narrative of transition from 'normal' to 'pathological', focussing instead on the structures that produce and the discourses that define or reinforce compulsive/dependent consumption. The remainder of this chapter will focus on interview material with two participants who, against the grain of the addict stereotype, are now former drug users. While Emma and Felix's example should not be thought of as representative of the experience of people who become drug dependent, their stories do highlight some important limitations of the framework of addiction.

Emma: A middle class addiction?

Emma grew up in a wealthy suburb on the lower north shore of Sydney. Still in her early-twenties, the usually smooth road from a seemingly privileged adolescence to a university educated young-adulthood was filled with difficult and unexpected circumstances. Emma's drug use commenced with smoking cannabis at 14 for "*calming down [and] chilling out*". She also took Xanax from her parent's bathroom cabinet and snorted them to "*kill anxiety*" and "*just as like jokes or whatever on the weekend*". By the age of 16 Emma was also regularly mixing alcohol and Panadeine Forte.

It was at this time that she met a charismatic young man named 'James', who was only one year her senior. One year into their relationship James sustained a debilitating back injury for which he was prescribed Panadeine Forte and OxyContin. After months without relief James started becoming depressed, in part because of his incapacitation from the injury, and the pair began crushing and snorting his prescriptions: *"my whole using [history], I had my partner, so you'll hear me refer to him a lot"*. After a few months Emma and James were regularly snorting PO like OxyContin and MS-Contin, which they continued to acquire from a friend who worked at a pharmacy. In the midst of a fierce divorce at the time, both of James' parents kicked him out of their respective homes, and as he moved in with Emma the pair continued to escalate their use of PO: *"[it] would be more to yeah just get high and relax... We'd just eat them [OxyContin] and watch a movie and ate pizza"*.

The next year of Emma's life presents a noticeable shift in her relationship with James and the medications they had been consuming together. As James' injury worsened, his depression deepened and he started to become abusive towards Emma: *"not abuse as in violent abuse, but he became very abusive... I mean you would rather be punched in the face than have these things said to you"*. After a little under a year of oral and intranasal PO use the couple's tolerance had grown significantly and James insisted that they start injecting the pharmaceuticals: *"by the end of it we would never swallow the pills, we would always crush them, taking the binders off, and shooting [injecting] them"*. Though the couple had been

dysfunctional for many months, the move to intravenous use put a serious strain on Emma and James' relationship.

Over the next six months James' abuse became more frequent and more extreme. He began to demand that Emma go out and buy drugs for him:

It would always be "I don't wanna leave" and he'd get really depressed and so he didn't want to leave the house. And so I always had to do it by myself, I always had to go to the city and everything. And I'm a pretty small girl, I'm 5 foot. It's not too hard to go "yeah I'm gonna pick you up and steal you".

Emma was 17 at the time. After a period of approximately 8 months of injecting OxyContin and MS-Contin, in August of 2008, one of the several "dealers" that Emma bought drugs from was not able to supply any oxycodone product and suggested she buy some heroin instead: "when we ran out of the pharmaceuticals and stuff we moved on to heavy drugs, so we moved on to the gear and the heroin and whatever".

After several months of intravenous heroin use, Emma's family were placing increasing pressure on her to leave James. Her growing resentment over James' abuse and demands eventually culminated in a dramatic end to their relationship. Emma asked James to leave the family home and cut ties with him, before entering a rehabilitation facility for opiate dependence. At the time of interview Emma had been clean from opiates for a period of 18 months. She is currently studying an undergraduate degree at university.

On reflecting about her time injecting opiates Emma often placed distance between her own experience injecting drugs and those of 'other' people, who were "*your typical kind of junkie*". She goes on to explain that "*normally [when I] tell people that I had a problem with heroin they go 'Pffft yeah ok'. And they even did when I was using*". Emma also spoke about never becoming homeless, never participating in sex work, never having to steal and never being convicted of any crime throughout her time using opiates:

I wouldn't be able to name any other female in the room [at rehab] who hasn't at some stage had sex with somebody for money or drugs, hasn't robbed someone, hasn't done all this stuff. [Other participants in the rehabilitation programme] are like "yeah, yeah you must of done this or that"... No, no. I just dealt pot and worked 20 plus a week.

Emma was adamant in insisting that her experiences injecting drugs did not fulfill the stereotype. For instance, when talking about James, she recalled: "*He stole from the family, which I just think is wrong anyway. I wouldn't steal from my Mum. He is the stereotype sociopath... I never did any of that stuff. I would never*".

Emma's trajectory of opiate use is structured in many ways by her middle class status. She explains "*in the lower north shore everyone's parents have it in their cupboard. I probably wouldn't be able to name one of my friend's parent's who isn't on Xanax, or Valium, or at least have it just in case*". The omnipresence of pharmaceuticals in the middle class homes that Emma grew up surrounded by inform a partial legitimisation of the use of pain

medications for emotional suffering: *"So I guess for me using numbed the pain or prevented it"*.

There are also significant intersections of gendered and class factors in Emma's experience with opiates. In the first instance it is important to note that being in an abusive relationship is a significant component of the drug use of many women and the link is well established in the literature (Wingood, DiClemente, & Raj, 2000). Emma's drug use does however involve other gendered elements as well. She describes a concerted effort to avoid any visible sign of her drug use, and thus the impression that she is a 'classless' or 'improper' woman. When comparing herself to *"more serious"* drug users and other women who use heroin, Emma says that *"I used to be a bit more delicate and careful"*. She made sure to inject in places that could be easily concealed and always used clean injecting equipment. The continued support of her parents also played an important role in her success in the rehabilitation program: *"I was really lucky, I mean I was in rehab with people coming down off OxyContin and stuff, and Jesus Christ! They did it so tough. I was really lucky!"*

While addiction was part of how Emma understood her experiences, it was clear that addiction was limited in its capacity to explain her time using PO and heroin. Emma often made distinctions between her and James' addictions: *"he's more the addict that you think of as like [the stereotype]... but I was more the addict that... I'd wake up in the morning and go to school and I'd go to TAFE and I'd work, and then I'd come home to Jake at 6 o'clock and I'd go get on for an hour"*. She was proud of the fact that she *"never missed work"* and *"didn't drop out of school"*. Moreover, she now has a very

different life than she did when using heroin: *“So I had a problem and I went to a rehab for that and umm... and I guess that was like two years ago. And now I’m working and I go to uni”*.

For Emma the structures of her upbringing and support of her family meant she was able to end her abusive relationship. Emma was not dependent on James and thus was, with the support of her parents, able to remove James from her life. She was also able to be funded and be emotionally supported through a quality rehabilitation program. All of this has meant that Emma is able to conceptualise her drug use as just a difficult period of her life. Unlike the stories of Mark and Jake in the previous chapter, life beyond addiction has become possible for Emma.

Felix: Injecting PO to get clean?

At the time of interview Felix was 31 years old. The first thing Felix shared in the interview was an explanation that, for many years before using PO he regularly injected heroin. He spoke in short considered bursts with a calm tone of voice that seemed to mask the chaos that had characterised much of his adult life. Felix had spent years in and out of the medical and social services that are scattered around the inner-city of Sydney and in counselling with mental health professionals. From the outset it was clear that Felix had engaged in an intense inner dialogue, over many years, about his own life choices. His considered responses left the lasting impression that, had he been born to a different life, Felix would have taken to

intellectual pursuits with great ease. However, the circumstances of Felix's life meant that he identified as an 'addict': "*I always conscientiously tried to stay out of the drug scene, but I was an addict so I don't know where that leaves you*" ('Felix' – Interview 2, 31 August 2012).

Felix spent most of his adult-life living on Darlinghurst Road, in the heart of Sydney's infamous Kings Cross region. Having spent so much time there Felix developed a foundation of friendships and relationships that characterised his late-teens and most of his twenties. Felix first injected heroin at the age of 19. His friends from the area made up a large part of that journey: "*it started off with interesting people, good friends of mine, intelligent kids, musicians you know*". Felix also started dating a young woman named Lisa he met as part of this circle of friends. Though he had injected heroin prior to dating Lisa, it was his time using with her that made drug use a 'normal' part of Felix's life: "*she made everything speed up and got me in a lot deeper a lot quicker than I would've normally I think... It all just became normal when I was with Lisa*".

Felix described Lisa as a "*thrill seeker*" with a "*troubled past*". She was particularly popular among his friends, and Felix felt a kind of privilege that she would choose him as her partner. Lisa's "*wild*" reputation operated as a kind of benchmark for the group: "*I always knew she was way further down the road than me, but while ever she was ok and trying to struggle [through], it felt like we were all kind of protected*". As the pair became more and more immersed in the drug scene, Felix's father rapidly pulled him out in May of 2003. Felix was put on a plane to Israel, where he was forced to sober up without any form of detoxification: "*I was with Lisa and injecting and I had a*

habit but nothing like what it ended up being – he just sent me off to Israel. So I got on a plane and went to Israel and just didn't sleep for a week”.

On his return from Israel Felix and Lisa started to drift apart, and as a result he delved deeper into drug use. His use of heroin soon became a lifestyle. Felix suffered through a tumultuous few years moving between homelessness and crisis accommodation for the period between 2004-2009. He survived this period of intense drug and lifestyle change by engaging in harm minimisation peer education and utilising a range of drug treatment programs. However this period of Felix's life had a lasting impact on his sense of self-worth. When describing unsatisfactory encounters with counsellors Felix reflects:

I've had people tell me before “oh you're so complex and intelligent” and this and that. That doesn't really help you at all. That really messes with your head if anything. I mean thinking that you're smart doesn't do you any favours.

Felix felt that his decision to inject heroin excluded him from the realm of intelligent, productive society and that his journey toward sobriety was the only path to that goal.

In 2009 Felix decided to switch from heroin to injecting PO as part of an attempt to more easily regulate his opiate intake. He reflects *“I was using them for a long time, OxyContin and MS-Contin I mean, as a replacement originally for heroin”*. Felix recalled that being able to know how the drug was made and what dose he was injecting meant *“it felt safer”*: *“heroin*

quality fluctuated so much it was so hard to work out what you're getting... So OxyContin became a far more stable thing for most of the Cross". Establishing a more regulated relationship with his opiate intake was particularly significant for Felix:

once you're addicted you need the stuff to function, so you know you're in no position to ask hospitals for it or anything but you generally do need some kind of opiate or synthetic opiate to function. But if you don't [know] what you're getting then it's hard to manage it... Oxys give you that certainty

His transition to PO injection was also accompanied by taking up a range of other harm minimisation services. Felix started visiting Sydney's MSIC more often and he began administering his PO with a 'cold wash' method recommended by the staff there: "*[you] do a cold wash up at the Injecting Centre because it's healthier*".

Indeed Felix reveals how he owes his life to the culture of harm minimisation that has come to characterise much of the health and social services of Sydney's Kings Cross district: "*those services are good because it makes you feel like you can help people and yourself, like you forgot you're even capable of that*". Yet in trying to come to terms with the moral weight attached to his time injecting drugs on the streets of Kings Cross, Felix also comments that: "*I was involved in a lot of... harm minimisation and peer to peer education. So the line gets really blurry between that and the fact that everything that you're doing is illegal*". Felix describes an internal conflict

about how to reconcile the illegality of his drug use alongside, what he regards to be, the necessity of peer education of harm minimisation. This internal conflict is reflective of broader debates about the role of harm minimisation and its potential to apparently encourage 'risky' drug taking practices.

After approximately 8 months injecting PO Felix enrolled in a methadone program and began looking for work. Having learnt how to manage his own opiate intake with PO was described as an important part of his success in the methadone program. In describing the six months before he was stabilised on methadone Felix remarked: "*ultimately I'd be looking for [OxyContin] to keep myself together so I could function*". As he began to seriously consider sobriety, Felix reflected:

You get this horrible tiny little window where you can function. But then if you're too stoned obviously at job interviews and things you look terrible. Whereas if you don't have anything that day you're sick and then you're not able to do anything. So you've got this horrible little window that you can function.

His use of painkillers was thus an important way in which he could gain some level of control over the window of functionality.

The way Felix was using PO has clear links to the way methadone is prescribed to people who are opioid dependent. Felix's use of PO can be thought of as part of a personalised form of opioid maintenance. Indeed

after entering a methadone program in 2010, Felix made comparisons to his use of painkillers and the treatment he was undertaking:

while [methadone] stabilises the use of these things it's still – I'm on that side of the opiate divide... Like there's this whole process of getting sick and detox that I can't go through. In some ways its pretty similar to the way I was using the Oxys, except it's not illegal now.

Felix was stabilised on methadone for 18 months before transitioning off the medication to become opiate free:

I got a really good doctor that took me on... I was lucky enough to get on the program and then lucky enough that my doctor, when he moved out – because he'd had enough of doing outreach – so he took me across to his practice and so I'm just one of his actual patients now.

Felix's use of painkillers is in part a response to the precariousness of the medical and health services available to those who are drug dependent. The injecting of PO was an improvised appropriation of the kind of medical maintenance (methadone) programs that are not easy to get access to, and for which it is difficult to find *"a good doctor who actually gives a fuck"*.

Felix's example is illustrative of how the surveillance and policing of PWID is often prioritised over a minimisation of the harms of drug use (Keane, 2003). For Felix, practices of improvised self-care (through injecting opioids as replacement therapy) and care for others (through peer-to-peer

education) emerge as important ways to maintain health and social support. These practices of care are not however ideal, and Felix's account of them is not a romanticised one. He spoke about difficulty reconciling the difference between his use for anxiety, pleasure and to regulate dependence:

I started feeling a lot of anxiety, and the withdrawals just make that worse. So originally it seemed to make a relief from that which was great... But like I said that line between just use and dependency is really hard to work out. You don't know where the line is until you've crossed it.

In saying so, there are a series of significant personal and social meanings that are associated with Felix's use of painkillers that cannot be explained by a language of 'abuse' or the concept of addiction. Where the medical/epidemiological literature prioritises the avoidance of any intravenous drug use, and its associated harms, PWID are more likely to worry about how to avoid arrest or overdose. Moreover, Felix's example raises complex questions about the different stages of his use and how addiction factors into them. Does his use of PO to regulate opioid intake represent a continuation or disruption of his addiction? What then does this mean for his use of methadone for 18 months? How are we to understand his subsequent detoxification and sobriety? Is it possible that Felix injected painkillers to 'get clean'?

The sections that follow use the examples of Emma and Felix to explore some of the limitations of addiction discourse and to address sociological concerns about the formulation of addiction. The next section

deals specifically with the epidemiological literature about transitions from oxycodone to heroin.

From PO to heroin

As discussed earlier, one of the central components of mainstream addiction discourse as well as a prominent feature of bio-medical accounts of addiction has been the notion of transition – from ‘normal’ person to ‘addict’, from a ‘healthy’ to an ‘addicted’ brain. The introduction of this chapter outlined some of the media rhetoric about the apparent threat of OxyContin (and other PO) transforming otherwise ‘normal’ people into desperate ‘drug addicts’. Part One of the thesis outlined how medical models of addiction claim that the use of drugs (like OxyContin and heroin) alter the neurochemistry of the brain to create a ‘pathological’ desire for the pleasures of drug use. This notion of ontological or biochemical transition to addiction also informs epidemiological research about transitions from licit to illicit opiates. Here it is worth recalling the historical and social construction of distinctions between licit and illicit opiates outlined in Chapter Two. There is no necessary pharmacological distinction between OxyContin and heroin that makes addiction to the latter more likely. There are however important considerations to be made about involvement in the political economy of the illicit drug market and criminalised cultures of IDU.

Though overrepresented in the literature, opioid dependence, transitions between oral and intravenous use, as well as prescribed and

illicit opiate use are genuine public health concerns. This section will canvas epidemiological literature about transitions between licit and illicit opiates. While qualitative literature about processes of transition in the Australian context is limited (Dertadian & Maher, 2013), an emerging set of North American studies has begun documenting transitions from the non-medical or recreational use of PO to intravenous and heroin use. In a recent qualitative study of PWID in Montreal the authors observed that the proportion of participants reporting the injection of PO increased from 21% to 75% between 2005 and 2009, while the prevalence of other drugs like heroin and crack use remained stable (Bruneau et al., 2012). Similarly, in a study of PO use among street-based young PWID (aged 16-25 years) in Los Angeles and New York City, Lankenau and colleagues state that 82% of respondents initiated non-medical PO use orally prior to injecting (Lankenau et al., 2012). Just over 80% of the sample of this study also reported non-medical PO use prior to first injecting heroin.

These data suggest that although most non-medical PO consumption often begins with oral ingestion, a minority may transition to the administration of opioids by injection and/or the use of heroin, typically within 2-3 years of initial use (Lankenau et al., 2012). A 2007 study from the US even poses the question "Is OxyContin® a "Gateway Drug"?" The study found that OxyContin itself is unlikely to *cause* escalating drug consumption, but that poly-opioid use, as well as poly-drug use more generally, is associated with quicker progression to intravenous and heroin consumption (Grau et al., 2007). While there is little evidence to suggest any plausible

causal link, data does suggest that, among a minority the non-medical use of PO may represent a 'new' pathway to IDU (Degenhardt et al., 2010).

There are aspects of Emma's experience with opiates that can provide important complements to current epidemiological data about transitions between opiates. Emma's transition between opiates was a largely linear process, from OxyContin to intravenous then heroin use, before entering rehabilitation and staying clean for 18 months at the time of interview. However it is important to consider how this linear transition may be structured by Emma's middle class status. The availability of PO in her own home and the homes of friends means that pharmaceutical medications can be thought of as 'soft' or 'safe' drugs. This reinforces the notion that heroin is a 'hard' or 'dangerous' drug that is unfamiliar and thus threatening to the middle class milieu of Sydney's north shore. This certainly had an impact on the way Emma related to addiction. For Emma, she never became a 'proper' addict, because that would have involved sex work, theft and deceit of her family – these were the practices of a different group of people that "*totally fulfilled the stereotype*".

In considering the classed elements of Emma's experience, it is also worth comparing them to that of other participants who transitioned from or between PO and heroin. Mark and Jake, introduced in the previous chapter, both began by using PO for pain and transitioned to intravenous and heroin use. Mark's continued use of PO outside the prescriptions of his physicians related mainly to the need to work, as well as the physical nature of his work. Similarly his transitions to intravenous and heroin use are marked by the bodily demands of physical labour, which Mark explains is

“the only thing I know how to do”. Mark’s attempts at detoxification and rehabilitation were many, but were largely unsuccessful. That he has a strained relationship with his family and says *“I have no meaningful relationship with anyone anymore”*, is telling of the lack of emotional support he would have been able to draw upon in attempts to reduce his drug use.

Unlike Emma, Jake’s drug use does not occur in clearly identifiable stages that can be neatly described as discrete transitions from oral to intravenous PO use and to heroin injection. Jake began using PO orally for approximately 18 months before entering a detoxification program. This was followed by a single instance of intravenous methadone use, then with periodic heroin injection. Following 6 months of house arrest, where Jake did not use opiates, he began injecting OxyContin while living in a homeless refuge. For years after being forced to leave his family home in the disadvantaged suburb of Campbelltown in Sydney’s south-west, Jake injected heroin and a wide range of PO interchangeably based on *“what ever is available and good at the time”*. Following a period of stabilisation on methadone Jake gave into a deep sense of loneliness and injected his prescribed dose, which was followed by a further period of intravenous heroin use. For Jake attempts at sobriety have been multiple and their success is described as partial and semi-permanent.

Support from family and friends, stable housing arrangements, as well as physical and conceptual distance from the criminalised/stigmatised context of street-based IDU are all components of Emma’s life that are not available to Mark and Jake. Such comparisons demonstrate that epidemiological literature may benefit from complementary qualitative

assessments of the complex life events and life circumstances that inform people's use of opiates. The significance of qualitative assessment is also highlighted by Felix's encounters with PO injection. Survey and other epidemiological research about transition are unlikely to capture alternative reasons for why people inject PO outside of a general 'pathway' to 'heroin addiction'. For Felix, PO injection was a way to stabilise his use of opiates, on his own terms. Furthermore, PO injection set him up well to manage methadone treatment and eventually stop using opiates altogether.

The epidemiological literature about PO to heroin transitions record important health information that deserves elaboration, however an overreliance on the psychopharmacological paradigm, which was problematised in earlier chapters, risks obscuring the social context in which IDU occurs. For instance, an uncritical acceptance of biomedical conceptualisations of 'addiction' may problematically present intravenous and dependent painkiller use, and any subsequent transition to heroin, as representative of practices of non-medical consumption. As the empirical examples in previous chapters have already illustrated, there are a broad range of non-medical practices that are in no way limited to intravenous or dependent consumption. Moreover, qualitative analysis of the life histories of people who inject PO and heroin can prompt complex questions about how the experience of addiction is structured by intersections between gender, class and medical discourse.

Agency in injecting drug use

The notion of 'lack of control' has long been central to addiction discourse (Foddy & Savulescu, 2010). Definitions of addiction and clinical diagnosis relating to substance use have often centered on the notion that the 'addict' is 'out of control'. The most recent version of the DSM – discussed in Chapter Three – includes diagnostic criteria directly related to 'control'. 'Impaired control' refers to the patient's inability to self-determine the amount of drug consumed. 'Social impairment' relates to the patient's inability to manage drug use to the detriment of work or other social activities. 'Risky use' indicates that the patient is unable to avoid drug-taking practices detrimental to their health. Biomedical models of addiction as 'brain disease' – canvassed in Chapter Four – indicate that prolonged drug use impairs the brain's ability to make decisions about drug use.

Despite a medical focus on 'lack of control' much public health policy and harm minimisation advocacy has focused on empowering PWID to make healthier choices about their drug consumption. Sometimes this comes in the form of social services to support PWID, while other times it involves a rhetorical deferral to the individual to 'take responsibility' for apparently autonomous choices about drug use. This section develops a conceptual discussion of the agentic capacity of PWID, and the way this relates to the lives of Emma and Felix. At the outset it is key to note that neoliberal discourse also utilise an emphasis on individual responsibility for health. As noted in Chapter Two, a defining moment for the harm minimisation movement was the establishment of NSP in the UK. The

Thatcher government's neoliberal policy agenda, which sought to make PWID responsible for their own health, provided a political framework that allowed PWID access to sterile injecting equipment. While harm minimisation has evolved into a broader social movement quite distinct from neoliberalism, the ability to empower the individual remains an important feature.

A set of critical literature has since sought to engage and problematise neoliberal discourse in health promotion about harm minimisation. Neoliberal health promotion often places a discursive focus on empowering PWID. Some scholars have actively embraced neoliberalism in order to position PWID within broader frameworks of legitimate consumption. FitzGerald and colleagues have for instance argued that a neoliberal reframing of people who use drugs allows for the ability to install them with "all the characteristics of non-drug users, the only different being that they consume an illegal commodity" (1999: 2).

Of course the consumption of an illegal commodity, or the consumption of a licit commodity under illicit contexts, has important consequences that cannot be overlooked. In Moore's study of public health material related to overdose prevention, he notes that PWID are presented as "individualized, rational, autonomous agent[s]... 'free' to choose to change 'risky' injecting practices" (2004: 1554). He goes on to suggest that this emphasis on the individual capacity to 'choose' not to engage in 'risky' injecting practices is at odds with ethnographic evidence that, within the "cultural logics of street-based IDUs, there are many valid reasons for

continuing to engage in practices that put them at risk of heroin overdose and other drug-related harm” (2004: 1554).

Fraser and Seear’s work on hepatitis C and its transmission among PWID drugs has noted that public health literature assumes that the “individual can and must control their health and that reducing incidence is primarily an individual responsibility” (2013: 4). The authors argue that the individual is central to contemporary public health, especially as it relates to hepatitis C and PWID. However the individual is more than simply a rhetorical device in health promotion. As noted in Chapter Four, the notion of the self-determining responsible individual is also a tool of governance that is both deployed by state authorities that seek to govern at a distance, and internalised by subjects. Fraser notes elsewhere that “the primacy of the individual in western culture is indeed reflected in hepatitis C and safe injecting materials, and... for a range of reasons, injecting drug users also make use of notions of individual responsibility” (2004: 200).

The assumed capacity to make ‘healthy’ choices is thus at odds with much of the medical literature’s emphasis on the way drug use impairs the agentic capacity of PWID. This is particularly problematic because much public health literature claims to be informed by the most current developments in addiction science and medicine. Moreover, the focus on individual responsibility in much public health literature ignores an abundance of qualitative research that suggests that the agentic capacity of PWID is often mitigated by important socio-structural barriers. Fraser (2008) and Moore’s (2004) work has often advocated for a cautious negotiation of the messages of empowerment that make services like NSP

possible, as well as a recognition of the social structures that mediate the individual's access to such resources. They recommend:

mobilisation of the neo-liberal subject in relation to drug users, producing analysis that acknowledges the value of doing so, but calling for the need to consider the context in which the subject operates in conceptualising the responsibilities and capacities of the individual drug user. (Moore & Fraser, 2006: 3040)

Keane's (2003) critique of the harm minimisation philosophy provides a slightly different approach that does not rely on an oscillation between the denial or empowerment of agency. For Keane the 'freedom' of people who use drugs is not a pre-existing state that can simply be allowed or denied by public health policy. Instead Keane argues that agency is a socially constituted capacity produced and mediated by an assortment of discourses, policies and personal circumstances. Keane's approach provides a compelling framework for explaining the agentic capacity of PWID, especially as it relates to the lives of Emma and Felix.

In interviews with PWID a sense of self-sufficiency was often foregrounded. Marginalisation from traditional forms of social and medical support produces an intense reliance on the individual. Emma is adamant in her insistence that, even during her time injecting opiates, she was still productive and self-reliant. She described herself as a "*highly functioning addict*", reporting that she would still "*wake up in the morning and go to school and I'd go to TAFE and I'd work*". While addiction explains aspects of

Emma's experience, she was very much in control of many aspects of her life and drug use. Felix's use of PO also demonstrates a significant exercise of agency while injecting drugs. Felix used PO as a form of improvised medical maintenance, which formed part of a conscious decision to "*get my shit together*".

While self-reliance is a key feature of the way these participants spoke about intravenous opiate use, this sense of responsibility for their own health and social welfare was also often placed within the context of unavoidable circumstances and social marginalisation. Emma rejects a complete responsabilisation of her transition to intravenous and heroin use, saying:

It's hard because I believe in the concept of not 100% blame. So in these statements, I say that 'yes, it was my fault'. But I was in a really abusive relationship, and it was painful, it was really painful.

Emotional pain at the hands of an abusive partner structured Emma's choices in complex ways: "*[it] sounds really weird, but I was half doing it because um I wanted to get high and half just because I wanted a fucking break from James*". When describing his experiences injecting drugs Felix is also critical of the structures that make the lives of PWID so precarious. In making this criticism, Felix uses the metaphor of opiate use as a fire in a cave. Within the metaphor individual emotion and social marginalisation are like a storm raging just outside the cave: "*And you're trapped in the cave because your wet, and you've got to keep feeding the fire*".

Participant perspectives also departed from the kind of individualised self-care promoted in neoliberal discourse. The need to care for others was an important feature brought about by the circumstances of IDU. Emma recalled that, after a frightening encounter with some people who sold her drugs, in which a group of men forced her to use in front of them, those men soon became trusted friends: *“once that happened, they were all very protective of me... Even when I got clean, my main gear dealer came and visited me in rehab. They were really proud of me, really proud”*. As noted above, Felix took the notion of peer-to-peer education of harm minimisation very seriously. He was active in sharing health information to people new to injecting. Felix showed novice injectors where to acquire sterile equipment, helped them to locate the MSIC and informed them about services related to the transmission of blood-borne infections.

These accounts demonstrate that cultures of IDU structure the agentic capacity of PWID. Social marginalisation encourages self-reliance and harm minimisation services can empower PWID to take control of their health. However marginality also encourages care for others who occupy similar life-circumstances. The participants’ capacity to care for the self and others is however inseparable from the conditions of street-based cultures of IDU. The capacity to change injecting behaviour, avoid overdose, or ‘get clean’ is thus intimately tied to the social context and political economy of their use of pain medications. As is demonstrated with Felix’s example, painkillers can play a very different role in the lives of PWID than what much of the current literature describes.

Conclusion

Social research perspectives demonstrate that the framework of addiction provides only limited explanations for drug use. Rather than a focus on how drugs effect individual bodies or on how individual psychology affects choices about drug use, sociologists have instead focussed on the structures that shape or produce dependent consumption. In the tradition of such social research this chapter has sought to focus on drug use as a social practice or experience (Fraser, Moore & Keane, 2014: 3).

For instance, Emma's example demonstrates how gender and class frame the 'addiction' experience (and drug use more generally) in particular ways. While Felix's example illustrates how the stigmatisation and criminalisation of IDU and addiction can produce individualised appropriations of health and medical practice. Moreover, Emma and Felix are both examples of people for whom there is a life beyond addiction. The idea that people can in fact move on from the 'addict' identity allows for a critical exploration of drug use more open to the sociological imaginary.

This chapter has addressed two key sociological critiques of addiction as it relates to the intravenous use of PO. An exploration of epidemiological literature about transitions from licit to illicit opiates highlighted the significance of complementary qualitative analysis. The intricacies of transition from and between intravenous opioid use complicate the dominant cultural meaning of licit and illicit drugs. The complexity of the legal status of opiates also calls attention to the political economy of cultures

of IDU and how they impact upon intravenous and dependent consumption. Social science literature about agency in drug use highlights how the choices of PWID are structured by policy, discourse and personal circumstances.

The conceptual and empirical discussion in this chapter has foregrounded the role of gender and class, the political economy of IDU, neoliberal discourse and harm minimisation policy. Understanding how these elements of the use of PO intersect constitutes an important tool in thinking beyond 'addiction'.

Conclusion

This thesis has explored the historical and conceptual elements of non-medical consumption, as well as the lived experiences of those who themselves use painkillers. It has traced the social meanings of opiate and analgesic consumption through its legal, medical and political histories. The thesis has sought to contextualise an emerging discourse of 'abuse' surrounding the consumption of pharmaceutical analgesics within these broader social parameters. It has also explored the way medical and commercial discourse shape contemporary understandings of pain, and how pharmaceutical medications are used to manage human suffering.

The primary empirical component of the thesis examined how pain medications can form part of broader process of the normalisation of drug use. It also explored how the ubiquity of pain medications has made them ideal complements to everyday cycles of restraint and release. Part Two has also provided a critique of, and posited alternatives to, the notion of addiction. Ongoing physical and emotional pain can make people reliant on medication. The stigmatisation of ongoing medication consumption also draws significant comparisons to the marginalisation of PWID. The social construction and social determinants of 'addiction' were also explored in order to unpack the limitations of the psycho-pharmacological frameworks that dominate contemporary understandings of drug use.

This conclusion will draw together the key concerns of the thesis to develop some overarching conclusions about contemporary understandings

of pain, neoliberal theory and medical authority. The conclusion will also elaborate on some of the implications of the findings of the thesis for future directions in theory, research and policy.

Reconceptualising pain

Pain is central to the kind of medication consumption discussed throughout the thesis. More traditional accounts of physical distress have featured as an important part of how people understand pain and get access to pain medications. A range of study participants consumed medications left over from direct prescriptions related to physically painful conditions. For some participants relief from intense or prolonged physical distress was itself experienced as pleasurable. Moreover, many participants also indicated that they only discovered the intoxicating potential of pain medications when simply trying to relieve pain. There are however other than physical elements to pain that have been explored throughout the thesis, and which will be the focus of this section.

A key element of the reconceptualisation of pain throughout this thesis has been to recognise the way physical and emotional discomfort is governed. Examples throughout the thesis have illustrated how pain impedes social interaction and hinders productivity, and thus often requires immediate (medical) intervention. Under such examples pain becomes a political and economic category, subject to the governing practices that comprise broad areas of human life: some of which include social

interaction, workplace relations and health practice. The structures of late-modern society thus play an integral role in the way pain is experienced and analgesic medications are consumed.

Sociological accounts about the conditions of late-modern society are useful in explaining how social structure can inform experiences of suffering (Bourdieu, 1999). Contemporary social theory has described how risk and uncertainty have become central to the modern condition (Beck, 1992). Buaman's work in particular is salient for a discussion about the relationship between social conditions, emotional worry and medication consumption. His theorisation of liquid modernity describe how contemporary society is "incurably fragmented and atomised, and so incredibly uncertain and unpredictable" (Bauman, 2007: 14). Uncertainty features significantly in interviews with study participants.

One example of the role of uncertainty in medication consumption is the way the stress of working environments or the demands of domesticity impact on physical pain. The thesis explored how the imperative to take responsibility for others in your care (which often involves paid employment) can have a significant effect on physical (and especially chronic) pain. Stress about financial security and the health and well being of loved ones can compound physical discomfort and may even affect unexpected flare-ups of chronic pain. These examples demonstrate that physical pain does not exist in a vacuum and that it cannot be separated from the social environment in which it is experienced. In this way, the accounts of physical pain provided in this thesis support the broad movement towards a biopsychosocial model in pain medicine.

Physical discomfort is not however the only form of pain discussed in the thesis. While pain medicine places emphasis on the role of the social and emotional in the experience of physical pain, the specialism is largely silent on the issue of social or emotional difficulty being painful in-and-of itself. A small but growing body of scientific research has begun to explore the common neurological responses induced by physical, social and emotional suffering. Many of the empirical examples within this thesis present important complementary qualitative evidence about the way social conditions and emotional responses are experienced as painful.

Discomfort from stress at work and the way this affects the capacity to work are key examples. Managing the stress of paid employment in the context of accelerated yet increasingly precarious working environments informs feelings of anxiety. In such a context people use pain medications to help manage stress at work, both in anticipation of physical illness and as a result of discomfort induced by intense worry about work. This is particularly the case for those in part-time and casual employment, who need to be seen as 'always on' to remain appealing to employers in order to secure temporarily renewed or future employment. The addition of educational or domestic responsibility often compounds the demand to flexibly manage financial and social life. These conditions are also gendered in a range of ways. The masculine imperative to demonstrate worth through financial means informs men's anxious use of pain medications to remain productive. While for many women social pressure to both work and care for dependent children compounds social and emotional worry about their performance as employees and mothers.

The way work, chronic pain and dependence are intertwined also raises important questions about forms of social suffering. For those who experience chronic pain, continued use of pain medications is as much about the need to work, participate in social activities and family life as it is about physical injury. Physical and other labour become difficult when experiencing chronic pain, especially when flare-ups of such pain occur in unpredictable ways. Similar experiences of uncertainty may also surround the ability to have a social life or be involved in family activities. Dependence on the use of pain medications to function is thus inseparable from the imperative that pain interrupts important elements of everyday life. For those experiencing chronic pain the distinction between medication use in response to pain and medication use in anxious anticipation of pain becomes difficult to distinguish.

Beyond the connection between physical pain and paid work, there are other ways in which drug dependence is linked to pain. Difficult emotions have long been regarded as a pathway to injecting and dependent drug use. Discussion of the lives of many of the participants in this study builds on established evidence that emotional anguish can inform problematic and dependent drug consumption. In saying so, it is important to note that for many people who use drugs emotional pain and drug dependence cannot be separated. Moreover, the experience of drug dependence can also be thought of as a form of suffering in-and-of itself. Opiate withdrawal is not only physically debilitating but it also reduces people's capacity to participate in society. For instance opiate withdrawal hinders the capacity of the person experiencing it to attend or 'perform well' in a job interview. The

need for immediate relief from the painful and debilitating sting of withdrawal is thus an important feature of the experience of opioid dependence.

Beyond withdrawal, there are also broader social dimensions to the pain of those who become drug dependent, and especially for PWID. The moralising implications of addiction discourse can have a transformative effect on the social status and self-concept of those who become drug dependent. Familial and social support tends to fall away when medical practitioners and social networks become aware of injecting and dependent drug use. The lives of PWID are thus incredibly precarious. Being marginalised from wider society in this way erodes people's self-esteem, and can produce painful emotions related to reflections about one's own self-worth.

The contexts outlined in these examples are illustrative of the fragmentation of social relations discussed by social theorists more broadly. Large social institutions such as the nuclear (and supportive) family, scientific medicine and full time employment are less reliable as foundations of support for vulnerable people. Bauman notes that, under such conditions "all drawings of a line are provisional and temporary, under threat of being redrawn or effaced, and for that reason they provide a natural outlet from the wide range of anxieties born of an insecure life" (Bauman, 2007: 80). Medication consumption becomes the answer to anxiety about insecure and uncertain life-circumstances. Commercial and medical discourses provide culturally intelligible frameworks for legitimising people's feelings of anxiety and their consumption of pain medications to alleviate it. The next

section will elaborate on the contradictions inherent in the imperative to find individualised responses to precarious and uncertain social conditions.

Neoliberal individualism

An important component of this thesis has been an exploration of the role of neoliberal discourse in practices of non-medical consumption. Historical and conceptual analysis in Part One outlined how neoliberal economic policy has impacted on the provision of social services, and the role this plays in the development of problematic drug use. Part One also explored how a neoliberal focus on the individual can erode support for individuals who are unable to 'take responsibility' of their own health. This focus on and deferral to the individual is a key feature of the commercial push for 'self-care', in which pharmaceutical and other industry bodies advocate for an expansion of consumer access to pharmaceutical medications.

Social theory is largely critical of the way neoliberal discourse espouses a-political 'empowerment' of the individual because this does not take into account structural impediments to the accessibility and actionability of knowledge about health. While this thesis has demonstrated that there are many and various structural impediments to the neoliberal ideal of individual consumers 'freely' managing their own consumption, it also acknowledges that people who use analgesics non-medically take up this kind of individualist discourse. The use of painkillers at work provides a significant example of how non-medical consumption can be informed by an

imperative for individualism. As already mentioned in relation to pain, people engage in non-medical use in a range of ways at work. Pain from a headache or anxiety over work is met with individual appropriations of medicalised and pharmaceuticalised processes.

For instance painkillers are used pre-emptively to 'bulldoze through' work, respond to stress and manage lack of sleep. The imperative to 'do whatever it takes' to stay healthy is thus connected in important ways to the imperative to 'do whatever it takes' to be a productive (and thus valued) worker. In this context of intense focus on productive work the medical connotations of pharmaceutical analgesics sometimes feed into consumer rhetoric. The painkiller becomes one product among many on the supermarket shelf that can be used to 'pep you up' and 'keep you going'. Neoliberal discourse thus informs potentially lucrative (and exploitative) notions of the responsabilisation of productivity and the freer use of medication in order manage the flexibility required for modern work.

The relationship between 'working hard' and 'playing hard' is also informed by elements of neoliberal discourse. The imperative to be productive is tied in important ways to forms of commercial consumption that allow the 'release' necessary for the continuation of the capitalist cycle of production and consumption. The consumption of alcohol is thus a significant component of neoliberal and commercial interest in the productivity of the modern worker. Use of painkillers to enhance 'time out' rituals of alcohol intoxication is a key example of an individualised appropriation of the established and thus legitimate social order. However, as examples in this thesis have demonstrated, for young people in particular

the influence of the neoliberal imperative for individualism is not restricted to appropriating 'legitimate' forms of consumption.

The use of illicit drugs is also associated with the subversive appeal of forms of 'risky' consumption. Here it is also worth elaborating on and fully conceptualising the way the 'risks' posed by unproductive bodies and recreational consumption is negotiated. Edgework scholars have described how the conditions of late-modernity may encourage risk taking. The ideals of capitalist accumulation are built around 'high risk' investments and stock market exchanges that produce 'high rewards'. The domain of commercial sport and leisure increasingly incorporates 'extreme' and 'risky' activities like blood sports and base-jumping. For many young people the appeal of risky behaviour is built into the social structures that inform their identity formation.

While social conditions produce a demand for productive work and healthy living, as well as excitement and risk taking, the circumstances of modern life rarely meet such expectations. Within criminological literature men in particular are thought to respond to the relative boredom of their everyday life by defying risk and revelling in the 'danger' of activities like drug use. This is certainly part of the way many young men spoke about recreational consumption throughout the thesis. Importantly however the notion of 'revelling in risk' also formed a central element of women's response to the boredom of domesticity or the pressures of managing both professional and domestic responsibilities.

A key feature of the experiences of the lives of young people in this study is recreational and analgesic drug use as a way to 'escape' everyday

life. Literature about the normalisation of recreational drug use has noted how young drug users are increasingly treating illicit substances like they would a commercial product: they weigh up the potential harms, cost, social repercussions and possible pleasures to make informed decisions about the consumption of illicit drugs. The expansion of neoliberal rhetoric may thus be eroding trust in medical and public health knowledge about drug use, instead shifting the focus onto individual experiences with drugs and their harms.

Young people respond to public health concerns about recreational drug use by using painkillers, or adding painkillers to a combination of recreational drugs. The use of painkillers means they can avoid the dangers of engaging illicit drug markets and provide certainty around the quality of the drug they are consuming. This means that young people can 'stay safe' while engaging in recreational consumption, and that they can do so by circumventing the moralising and punitive elements of medical and policing approaches to drug use. While a medical practitioner does not for instance sanction the use of painkillers to 'come down' from ecstasy, use of analgesics in this way clearly has medical intention.

Examples outlined throughout the thesis demonstrate that people take up elements of neoliberal individualism as a form of self-governance. Medication users take seriously the idea that they are "rational-choice agents capable of self-government" (O'Malley, 2004: 333). Productive capacity and the responsibility to consume are mediated by analgesic consumption through individualised appropriations of medical and health discourse. The imperative to rely on altered forms of medication use is tied

to contemporary constructions of productive citizenship and a tendency to defer to the individual to manage the uncertain aspects of modern life. The precariousness of the lives of people who are imbedded in cultures of IDU makes an emphasis on the individual particularly salient. However these improvisations of consumer and health discourse do not only produce individualised discourses.

While neoliberal individualism helps to produce an imperative for creative medication consumption, there are also collective and social aspects to non-medical consumption. Neoliberal individualism informs 'new' sets of practices that are subsequently expanded into more collective forms and are distributed through social processes. For instance, analgesic medications are often shared among friends, both to spread the benefit of recreational pleasure and the ability for peers to 'be safe' when using illicit drugs. For PWID information about how to use medications to alleviate chronic pain, difficult emotions and peer-to-peer education about harm minimisation when using PO are key ways of managing the lack of stability in cultures of IDU.

The examples outlined above are illustrative of a dialectic of neoliberal individualism. Non-medical consumption is neither fully individualised nor completely social. Practices of non-medical consumption involve a constant negotiation between structure and agency. This thesis provides important instances of neoliberal governance, but it also highlights how non-medical consumption is illustrative of the failures of 'governing at a distance'. That is, the individualising imperative of neoliberal governance can have unintended consequences that encourage people to be 'enterprising' and

'innovative' (rather than compliant) in their dealings with legal and medical authorities.

Medicine, discourse and power

Medical and scientific knowledge have important impacts on the way painkillers are consumed. The work of Foucault has been particularly influential in empirical and theoretical analysis of medical knowledge and drug consumption. This argues that knowledge is central to the operation of power, which can be both repressive and productive (Foucault, 1980). Medical knowledge does not simply describe self-evident pathologies; rather it is central to and productive of pathologies related to drug use. This involves both the way medical knowledge informs legal distinctions between kinds of opiates and biomedical discourse about their impact on the human body.

The way medical knowledge informs legal distinctions between kinds of opiates is a significant theme throughout the thesis. Part One outlined how the convergence of medical and political knowledge throughout the twentieth century produced and entrenched distinctions between kinds of opiates and the people who consumed them. Political rhetoric addressed and perpetuated concern about the apparent depravity of the hedonistic 'Chinaman' and the vice of urban youth. In response, legal frameworks were produced around drugs like heroin to make them illegal and thus reproduce the idea that they could only cause harm and suffering. At the same time

medical frameworks defined morphine (and later OxyContin) as medical technologies that heal or reduce the suffering of the body. These frameworks inform socially constructed distinctions between the legitimate consumption of pharmaceutical products and the illegitimate consumption of illicit drugs. Such distinctions, between 'legitimate' pharmaceutical consumption and 'illegitimate' illicit drug use, are challenged by an emerging discourse of painkiller 'abuse'.

The medicalisation and pharmaceuticalisation of work-related-stress is a key empirical example. Physical manifestations of stress affect the productivity of the modern worker and this has recently been the subject of increased medical intervention. Pharmaceutical companies have sought to capitalise on social anxieties about productivity by producing advertisements for analgesic medications that present pain as an impediment to work – and thus also position the consumption of their products as a way to be more productive. Medication users take up aspects of this part-medical-part-commercial ethos by using painkillers to prevent, pre-empt or interrupt discomfort or illness.

Observations about preventative consumption are particularly pertinent in light of the notion that medical-science does not simply articulate pre-existing disease-states or biomedical facts. Rather medical/scientific knowledge constitutively produces particular understandings of disease and biological realities. This has important impacts on the way people experience the uncertain conditions of modern society. Feelings of anxiety and other emotional responses are thus also

medicalised and pharmaceuticalised in a range of ways, involving a specific set of legitimate medical treatments.

As discussed in Chapter Four the medication of emotional pain has a long history. The most direct form of medical intervention into emotional discomfort came in the form of pharmaceutical tranquilisers ('happy pills' and 'emotional aspirin') during the 1960s. Since the introduction of tranquilisers, medical treatment for social and emotional unease has been expanded to include a wide range of pharmaceuticals such as anti-depressant and stimulant medications. However, as examples in this thesis have illustrated, when medical interventions are not available or do not meet cultural expectations about therapeutic potential, medication consumers appropriate 'legitimate' treatments through creative consumption. In this context, the loss of a loved one, dealing with an abusive partner, and managing the marginalisation involved in cultures of IDU, become ideal circumstances to appropriate medical discourse.

Critical analysis of medical knowledge is also required to unpack the moralising imperative of addiction discourse. The medical model has become a prominent way of understanding regular or prolonged drug use. People who use drugs even internalise aspects of the medical model of 'addiction as disease'. While addiction is widely regarded as a genuine biomedical disease in medical literature, this does not necessarily ameliorate the moralistic elements of addiction discourse more generally. Medical practitioners often treat people who use or inject drugs with deep scepticism, significantly impacting the kind of treatment and care on offer. The institutionalisation of 'addiction as disease' has been influential in

producing drug use as a 'legitimate' medical condition, however it also informs the lived reality of the 'addict' who is treated as an illegitimate patient and often as not deserving of treatment.

The reluctance of many medical professionals to treat PWID like 'ordinary patients' with a 'legitimate disease' adds to the fragmented and uncertain circumstances of their everyday lives. This is also compounded by the limited availability of services for drug dependence. The moralisation of addiction and the scarcity of services contribute to the way pain medications are used to manage opioid dependence. The use of PO to stave off withdrawal is seen as 'safer' and easier to predict. This predictability provides some sense of certainty in precarious circumstances. The use of a pharmaceutical alternative to heroin in order to medically maintain patients has been available in Australia since the 1970s. Conscious use of PO to avoid heroin thus represents an acknowledgement of the therapeutic potential of pharmaceutical intervention. It may even be argued that PWID internalise medical models of drug use, so much so that they appropriate medical treatment like OST when those services are not available or convenient.

The role of medical discourse and power has been a recurring theme throughout the thesis. Medical discourse constitutes feelings of anxiety about uncertainty as a biomedical reality that has a pharmaceutical solution, it consolidates neoliberal notions of appropriate production and consumption, and it colonises the common understanding of prolonged drug use as a medical condition. While people certainly adopt these external structures, they also bend and subvert aspects of medical authority. In this

light non-medical consumption is best thought of as a conditional appropriation rather than a rejection of medical power.

Final comments

This thesis has drawn on scholarship about the structure of late-modern society as well as on the lived realities of drug consumption. The work of Beck (1992), Bauman (2007) and Foucault (1973) has informed broad observations about risk, uncertainty, and medical discourse. Using aspects of these theoretical projects this thesis has described how pharmaceutical consumption helps to constitute the subject in pain, the neoliberal citizen and the identity of the 'drug user'. The thesis also incorporates the work of key thinkers in Australian poststructuralist drug research. Scholars such as Keane (2002), Fraser (2004), Moore (2010) and Duff (2005) have developed important tools for understand drug use as a social practice. This work has made an important contribution to the way the thesis has addressed debates about productive consumption, health citizenship, pleasure and normalisation, as well as critical approaches to addiction.

This collection of scholarship informs key claims about pain medications and their consumption throughout the thesis. The project has critically examined a discourse of 'abuse' that has emerged around the non-medical consumption of painkillers. It has traced historical evidence that reflects how the danger and harm of different drugs shifts over time, often related to matters of professional control rather than scientific clarity.

Emphasising the historicity of a drug's 'harmful properties' also revealed the way knowledge about drugs often conflates a range of levels of drug consumption and exaggerates its relationship with criminality.

In contrast to the presentation of the painkiller as a 'dangerous drug' the medicalisation of society has paradoxically fostered higher public expectations about the therapeutic qualities of pharmaceuticals and subsequently medicine's ability to cure and control the body. Higher expectations about therapeutic medicine have informed a cultural context that demands a 'pill for every ill'. The development of a pharmaceutical 'pill culture' has also resulted in an expanded understanding of pain as well as the medical promise to alleviate it. These expectations, alongside ideas of preventive self-regulation and self-care now represent a significant threat to medical authority.

The threat creative medication consumption poses to medical authority appears to be feeding contemporary concerns about non-medical 'abuse'. Yet a critical assessment of a growing set of research and the analysis of interview data suggest that non-medical consumption is commonplace and disparate. Contrary to the stereotype of the 'seductive' drug that coaxes its user into a life of dysfunction, there appears to be an intimate relationship between the motivations of pleasure seeking, health practice and productive citizenship.

Future directions

The kinds of medication consumption articulated throughout this thesis have important implications for social theory, future research and policymaking. For instance, the conceptual and empirical discussions canvassed throughout this thesis demonstrate the limitations of theoretical approaches that assume classic modernist institutions (such as medicine and capitalism) impose their authority only as a repressive force. Changes in the modern condition brought about by more dispersed and fragmented social relations, alongside the emergence of neoliberal policy and discourse, have shifted the way modern subjects are governed.

Forms of neoliberal governance occur in dialogue with the way individuals enact 'self-care' through creative consumption. While this does not discount the potential for oppressive forms of social control, theorisation about medicalisation and capitalist commodification should incorporate recognition of processes of individualisation. Displacement or deferral to the individual is not simply an agenda of the elite and political classes. Neoliberal individualism is firmly embedded in the practice of those who are the subjects of medicinal authority and capitalist consumption. Moreover, neoliberalism both encourages the entrepreneurial or flexible use of medications and responsabilises problematic consumption as a failure to make 'healthy life choices'.

The challenge for further research is to recognise that non-medical use is not simply a matter of unauthorised or defiant consumption. Changing understandings of pain and cultural expectations about the therapeutic

potential of pharmaceutical drugs should be brought into the medical and epidemiological literature. A greater emphasis on or recognition of qualitative research would help to complement the clinical focus of the bulk of the current body of research. Qualitative research allows for the self-explanation of those who engage in the practice to form part of how it is understood and disseminated. Further qualitative research is thus needed on the social meaning of informal medication sharing and lay care practices so that forms of medication consumption are not unnecessarily pathologised and criminalised. This would allow for a fuller picture of the kinds of practices that comprise non-medical consumption, and the most appropriate responses to them.

It is also important for both researchers and policymakers to recognise that non-medical consumption is not a homogenous practice defined by a necessary transition to intravenous use and 'addiction'. As recently as April of 2015 the Australian Medical Association renewed its call for "a real-time record of patient prescriptions amid an alarming rise in doctor shopping and deaths" (Rollins). Supply-side policy approaches, such as the proposed introduction of an ERRCD, borrow heavily from international and domestic policy about illicit drug use. This convergence with illicit drug policy is built on the assumption that non-medical use is criminal and pathological. However, as this thesis has demonstrated, there are a range of practices that constitute the non-medical use of pain medications and they are by no means limited to 'abusive' or 'addictive' consumption.

Many of the practices discussed in this thesis reveal as much about the way contemporary society is structured as they do about the pharmacology

of the drug being consumed or the psychology of its consumer. Because non-medical consumption is tied to everyday experiences of productivity, consumerism, legitimate forms of intoxication (with alcohol), and common emotions, it cannot simply be dismissed as unimportant, nor dealt with as though it were congruent to injecting or dependent drug use. Assuming that the office or domestic worker, the occasional or recreational drug consumer and the injecting or dependent drug user have the same needs for services should be avoided. Research and policy needs to account for more nuance, both in its description of the range and the complexity of practices of non-medical consumption.

Reference list

- Acker, C. J. (2002). *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control*. Baltimore & London: The Johns Hopkins University Press.
- Aitken, C., Moore, D., Higgs, P., Kelsall, J., & Kerger, M. (2002). The impact of a police crackdown on a street drug scene: evidence from the street. *International Journal of Drug Policy*, 13(3), 193-202.
- Åkerstedt, T., Knutsson, A., Westerholm, P., Theorell, T., Alfredsson, L., & Kecklund, G. (2002). Sleep disturbances, work stress and work hours: A cross-sectional study. *Journal of Psychosomatic Research*, 53(3), 741-748.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*: American Psychiatric Publication Incorporated.
- Amos, A., Wiltshire, S., Bostock, Y., Haw, S., & McNeill, A. (2004). 'You can't go without a fag . . . you need it for your hash'—a qualitative exploration of smoking, cannabis and young people. *Addiction*, 99(1), 77-81.
- Armstrong, D. (1983). *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*: Cambridge University Press.
- Arria, A. M., Garnier-Dykstra, L. M., Caldeira, K. M., Vincent, K. B., & O'Grady, K. E. (2011). Prescription Analgesic Use among Young Adults: Adherence to Physician Instructions and Diversion. *Pain Medicine*.
- Australian Government. (2013). National Drug Strategy. Retrieved 01 February, 2014, from <http://www.nationaldrugstrategy.gov.au/>
- Australian Institute of Criminology. (2009). Key issues in alcohol-related violence *Research in Practice - Summary Paper No. 4*.
- Australian Institute of Health and Welfare. (2005). 2004 National Drugs Strategy Household Survey: Detailed findings. *Drug Statistics Series Number 16*. Canberra: Australian Government.
- Australian Institute of Health and Welfare. (2008). 2007 National Drugs Strategy Household Survey: Detailed findings. Canberra: Australian Government.
- Australian Institute of Health and Welfare. (2011). 2010 National Drugs Strategy Household Survey report *Drug Statistics Series Number 25*. Canberra: Australian Government.
- Australian Self Medication Industry. (2014). What is Self Care? Retrieved 21 April, 2014, from <http://www.asmi.com.au/self-care/What-Is-Self-Care.aspx>
- Bacchi, C. L. (2009). *Analysing Policy: What's the Problem Represented to Be?* : Pearson.
- Baer, W., & Maloney, W. (1997). Neoliberalism and income distribution in Latin America. *World Development*, 25(3), 311-327.
- Baily, M. N., & Lawrence, R. (2001). Do we have a new e-economy? : National Bureau of Economic Research.
- Bair, M. J., Wu, J., Damush, T. M., Sutherland, J. M., & Kroenke, K. (2008). Association of depression and anxiety alone and in combination with chronic musculoskeletal pain in primary care patients. *Psychosomatic Medicine*, 70(8), 890-897.

- Barbieri, P. (2009). Flexible employment and inequality in Europe. *European Sociological Review*, jcp020.
- Barker, C., & Galasinski, D. (2001). *Cultural Studies and Discourse Analysis: A Dialogue on Language and Identity*: SAGE Publications.
- Barker, T. (2010). *Biker Gangs and Organized Crime*: Elsevier Science.
- Baszanger, I. (1992). Deciphering chronic pain. *Sociology of Health & Illness*, 14(2), 181-215.
- Baudrillard, J. (1998). *The Consumer Society: Myths and Structures*: SAGE Publications.
- Bauman, Z. (2001). *The Individualized Society*: Wiley.
- Bauman, Z. (2003). *Liquid Love: On the Frailty of Human Bonds*: Wiley.
- Bauman, Z. (2006). *Liquid Fear*: Polity Press.
- Bauman, Z. (2007). *Liquid Times: Living in an Age of Uncertainty*: Wiley.
- Bauman, Z. (2013). *Liquid Life*: Wiley.
- Beck, U. (1992). *Risk Society: Towards a New Modernity*: SAGE Publications.
- Beck, U., Giddens, A., & Lash, S. (1994). *Reflexive Modernization: Politics, Tradition and Aesthetics in the Modern Social Order*: Stanford University Press.
- Becker, H. S. (1963). *Outsiders; studies in the sociology of deviance*: Free Press of Glencoe.
- Becker, W. C., Sullivan, L. E., Tetrault, J. M., Desai, R. A., & Fiellin, D. A. (2008). Non-medical use, abuse and dependence on prescription opioids among U.S. adults: Psychiatric, medical and substance use correlates. *Drug and Alcohol Dependence*, 94(1-3), 38-47.
- Bell, K., & Salmon, A. (2009). Pain, physical dependence and pseudoaddiction: Redefining addiction for 'nice' people? *International Journal of Drug Policy*, 20(2), 170-178.
- Bell, S. E., & Figert, A. E. (2012). Medicalization and pharmaceuticalization at the intersections: Looking backward, sideways and forward. *Social Science & Medicine*, 75(5), 775-783.
- Benoit, C., Zadoroznyj, M., Hallgrimsdottir, H., Treloar, A., & Taylor, K. (2010). Medical dominance and neoliberalisation in maternal care provision: The evidence from Canada and Australia. *Social Science & Medicine*, 71(3), 475-481.
- Benson, S. (2014). Hillbilly heroin flood fear, *The Daily Telegraph*. Retrieved from <https://global.factiva.com/ga/default.aspx>
- Berger, J. M. (2005). Opioids in anesthesia. *Seminars in Anesthesia, Perioperative Medicine and Pain*, 24(2), 108-119.
- Biggs, A. (2002). *The Pharmaceutical Benefits Scheme - an Overview*. E-Briefing - Social Policy Group Retrieved from http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/pbs.
- Billington, B. P. (1960). The Australian gastric ulcer change: Further observations. *Med J Aust*, 2, 19-20.
- Billington, B. P. (1963). The Australian gastric ulcer change: Interstate variations. *Aust Ann med*, 12, 153-159.
- Bissel, D. (2012). Placing Affective Relations: Uncertain Geographies of Pain. In P. Harrison & B. Anderson (Eds.), *Taking-Place: Non-*

- Representational Theories and Geography* (pp. 79-98): Ashgate Publishing, Limited.
- Blackett, T., & Robins, R. (2001). *Brand Medicine: The Role of Branding in the Pharmaceutical Industry*: Palgrave Macmillan Limited.
- Blackman, S. J. (1996). Has drug culture become an inevitable part of youth culture? A critical assessment of drug education. *Educational Review*, 48(2), 131-142.
- Blattner, W. A. (1991). HIV epidemiology: past, present, and future. *The FASEB journal*, 5(10), 2340-2348.
- Blomqvist, P. (2013). Citizenship, Choice and Social Equity in Welfare Services. In K. S. Helgesson & U. Mörth (Eds.), *The Political Role of Corporate Citizens: An Interdisciplinary Approach*: Palgrave Macmillan.
- Board., S. C. S. S. a. H. (1875). Eleventh Progress Report in New South Wales Legislative Assembly *Votes and Proceedings 1875-6* (pp. 535 - 661). Vol. V.
- Bourdieu, P. (1999). *The Weight of the World: Social Suffering in Contemporary Society*: Stanford University Press.
- Bourgois, P. (1995). *In Search of Respect: Selling Crack in El Barrio*. New York: Cambridge University Press.
- Bourgois, P. (2000). Disciplining addictions: the bio-politics of methadone and heroin in the United States. *Cult Med Psychiatry*, 24(2), 165-195.
- Bourgois, P. (2002). Anthropology and epidemiology on drugs: the challenges of cross-methodological and theoretical dialogue. *International Journal of Drug Policy*, 13(4), 259-269.
- Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal*, 9(2), 27-40.
- Boys, A., Marsden, J., & Strang, J. (2001). Understanding reasons for drug use amongst young people: a functional perspective. *Health education research*, 16(4), 457-469.
- Bradford, D., & Payne, J. (2012). Illicit Drug Use and Property Offending among Police Detainees. *Contemporary Issues in Crime and Justice*, 157, 1-12.
- Brain, K. (2000). *Youth, alcohol, and the emergence of the post-modern alcohol order*: Institute of Alcohol Studies London.
- Brereton, D. (2000). The History and Politics of Prohibition. In G. Stokes, P. Chalk & K. Gillen (Eds.), *Drugs and democracy: in search of new directions*: Melbourne University Press.
- Briggs, M., & Closs, J. S. (1999). A Descriptive Study of the Use of Visual Analogue Scales and Verbal Rating Scales for the Assessment of Postoperative Pain in Orthopedic Patients. *Journal of Pain and Symptom Management*, 18(6), 438-446.
- Brown, D. (2012). Tasmania taking the lead in the war on drugs. from <http://blogs.abc.net.au/tasmania/2012/06/tasmania-taking-the-lead-in-the-war-on-drug.html>
- Bruneau, J., Roy, É., Arruda, N., Zang, G., & Jutras-Aswad, D. (2012). The rising prevalence of prescription opioid injection and its association with hepatitis C incidence among street-drug users. *Addiction*, 107(7), 1318-1327.

- Bryant, J., & Treloar, C. (2007). The gendered context of initiation to injecting drug use: Evidence for women as active initiates. *Drug and Alcohol Review, 26*(3), 287-293.
- Burnley, I. H. (1982). *Population, Society and Environment in Australia*: Shillington House.
- Burrows, R., Nettleton, S., & Bunton, R. (1995). Sociology and health promotion: Health, risk and consumption under late modernism. *The sociology of health promotion, 1*.
- Burton, F., & Carlen, P. (2013). *Official Discourse (Routledge Revivals): On Discourse Analysis, Government Publications, Ideology and the State*: Taylor & Francis.
- Butler, T., Levy, M., Dolan, K., & Kaldor, J. (2003). Drug Use and Its Correlates in an Australian Prisoner Population. *Addiction Research & Theory, 11*(2), 89-101. doi: doi:10.1080/1606635021000021403
- Campbell, N. D. (2007). *Discovering Addiction: The Science and Politics of Substance Abuse Research*: University of Michigan Press.
- Carney, M. (Writer) & Australian Broadcast Corporation (Director). (2010). *Oxy - The Hidden Epidemic, Four Corners*.
- Carney, T. (1981). The History of Australian Drug Laws: Commercialism to Confusion? *Monash University Law Review, 7*, 165.
- Castel, R. (1991). From Dangerousness to Risk. In M. Foucault, G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press.
- Catalano, J. (2009). Pain Management and Substance Abuse: A National Dilemma. *Social Work in Public Health, 24*, 477-490.
- Centre., N. D. a. A. R. (2012). Key Findings - Drug Trend Conference Handout *Australian Drug Trends 2012 - Findings from the Illicit Drug Reporting System*.
- Chambliss, W. J. (1995). Another lost war: The costs and consequences of drug prohibition. *Social Justice, 22*(2), 101-101.
- Chapman, C. R., Casey, K. L., Dubner, R., Foley, K. M., Gracely, R. H., & Reading, A. E. (1985). Pain measurement: an overview. *Pain, 22*(1), 1-31.
- Chatzitheochari, S., & Arber, S. (2009). Lack of sleep, work and the long hours culture: evidence from the UK Time Use Survey. *Work, Employment & Society, 23*(1), 30-48.
- Clark, N. (2010). Injectable diacetylmorphine is more effective than oral methadone in the treatment of chronic relapsing opioid dependence. *Evidence Based Mental Health, 13*(3), 80-80.
- Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and US biomedicine. *American Sociological Review, 161*-194.
- Cloward, R. A., & Ohlin, L. E. (1960). *Delinquency and opportunity: A theory of delinquent gangs* (Vol. 90559): Free Press New York.
- Cohen, M., Quintner, J., Buchanan, D., Nielsen, M., & Guy, L. (2011). Stigmatization of Patients with Chronic Pain: The Extinction of Empathy. *Pain Medicine, 12*, 1637-1643.
- Cohen, M. L., & Wodak, A. D. (2010). The Judicious Use of Opioids in Managing Chronic Noncancer Pain. *Medicine Today, 11*(2), 10-18.

- Cohen, M. L., & Wodak, A. D. (2012). Opioid prescribing in general practice: a proposed approach. *Medicine Today*, 13(1), 24-32.
- Cohen, S. (1972). *Folk devils and moral panics: the creation of the Mods and Rockers*: MacGibbon and Kee.
- Cohen, S., & Young, J. (1973). *The manufacture of news: social problems, deviance and the mass media*: Constable.
- Collert, S. (1977). Osteomyelitis of the spine. *Acta Orthopaedica*, 48(3), 283-290.
- Collison, M. (1996). IN SEARCH OF THE HIGH LIFE Drugs, Crime, Masculinities and Consumption. *British Journal of Criminology*, 36(3), 428-444.
- Commonwealth of Australia. (2013). About the PBS. Retrieved March 10, 2012, from <http://www.pbs.gov.au/info/about-the-pbs>
- Compton, W. M., & Volkow, N. D. (2006a). Abuse of prescription drugs and the risk of addiction. *Drug and Alcohol Dependence*, 83, S4-S7.
- Compton, W. M., & Volkow, N. D. (2006b). Major increases in opioid analgesic abuse in the United States: concerns and strategies. *Drug and Alcohol Dependence*, 81(2), 103-107.
- Conrad, P. (2008). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*: Johns Hopkins University Press.
- Conrad, P., & Leiter, V. (2004). Medicalization, Markets and Consumers. *Journal of Health and Social Behavior*, 45, 158-176.
- Conrad, P., & Potter, D. (2000). From Hyperactive Children to ADHD Adults: Observations on the Expansion on Medical Categories. *Social Problems*, 47, 559-582.
- Conrad, P., & Schneider, J. W. (1980). *Deviance and Medicalization: From Badness to Sickness*: Temple University Press.
- Conrad, P., & Schneider, J. W. (1992). *Deviance and Medicalization: From Badness to Sickness*: Temple University Press.
- Cooper, H., Moore, L., Gruskin, S., & Krieger, N. (2005). The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study. *Social Science & Medicine*, 61(3), 673-684. doi: <http://dx.doi.org/10.1016/j.socscimed.2004.12.030>
- Cooper, M. (2008). *Life as surplus: biotechnology and capitalism in the neoliberal era*: University of Washington Press.
- Cooperstock, R. (1976). Psychotropic drug use among women. *Canadian Medical Association Journal*, 115(8), 760.
- Cooperstock, R. (1978). Sex differences in psychotropic drug use. *Social Science & Medicine. Part B: Medical Anthropology*, 12(0), 179-186.
- Crawford, R. (1980). Healthism and the Medicalization of Everyday Life. *International Journal of Health Services*, 10(3), 365-388.
- Crowley-Matoka, M., & True, G. (2012). NO ONE WANTS TO BE THE CANDY MAN: Ambivalent Medicalization and Clinician Subjectivity in Pain Management. *Cultural Anthropology*, 27(4), 689-712.
- Cunneen, C. (2005). Racism, Discrimination and the Over-Representation of Indigenous People in the Criminal Justice System: Some Conceptual and Explanatory Issues. *Current Issues in Criminal Justice*, 17(3), 329-346.

- Dain, N. (1989). Critics and dissenters: Reflections on “anti-psychiatry” in the United States. *Journal of the History of the Behavioral Sciences*, 25(1), 3-25.
- Dallenbach, K. M. (1939). Somesthesia. In Baring E. G, Langfield H. S & Weld H. P (Eds.), *Introduction to psychology*. New York: John Wiley.
- Darke, S., Hall, W., & Topp, L. (2000). *The Illicit Drug Reporting System (IDRS) 1996-2000: History and development of a national strategic early warning system for monitoring trends in illicit drug use*. Randwick, NSW: National Drug & Alcohol Research Centre.
- Davey, P. J., Ramm, R. A., Ball, A. R., & Wilks, J. (1995). A profile of therapeutic opioid dependent persons in Queensland. *Australian Health Review*, 18(3), 76-90.
- De Vogli, R. (2011). Neoliberal globalisation and health in a time of economic crisis. *Social Theory & Health*, 9(4), 311-325.
- Dearne, K. (2012a). Electronic alert to end abuse, *The Australian*.
- Dearne, K. (2012b). Plibersek defends script alert system, *The Australian*.
- Degenhardt, L., Dierker, L., Chiu, W. T., Medina-Mora, M. E., Neumark, Y., Sampson, N., . . . Kessler, R. C. (2010). Evaluating the drug use “gateway” theory using cross-national data: Consistency and associations of the order of initiation of drug use among participants in the WHO World Mental Health Surveys. *Drug and Alcohol Dependence*, 108(1-2), 84-97.
- Degenhardt, L., Larance, B., Mathers, B., Azim, T., Kamarulzaman, A., Mattick, R., . . . Wodak, A. (2007). Benefits and risks of pharmaceutical opioids: Essential treatment and diverted medication *A global review of availability, extra-medical use, injection and the association with HIV*. Sydney: National Drug and Alcohol Research Centre, on behalf of the Reference Group to the United Nations on HIV and injecting drug use.
- Degenhardt, L., Larance, B. K., Bell, J. R., Winstock, A. R., Nicholas Lintzeris, Ali, R. L., . . . Mattick, R. P. (2009). Injection of medications used in opioid substitution treatment in Australia after the introduction of a mixed partial agonist-antagonist formulation. *Medical Journal of Australia*, 191, 161-165.
- Degrandpre, R. J., & White, E. (1996). Drug dialectics. *Arena journal*(7), 41.
- Denzin, N. K. (1987). *The alcoholic self*: Sage Publications.
- DePalma, M. J., Ketchum, J. M., & Saullo, T. (2011). What is the source of chronic low back pain and does age play a role? *Pain Medicine*, 12(2), 224-233.
- Dertadian, G. C. (2011). *Pill Heads: Governance, Normalisation and Risk in Prescription Drugs Use*. Paper presented at the 5th Annual Australian and New Zealand Critical Criminology Conference, Rydges Esplanade Resort, Cairns North Queensland.
- Dertadian, G. C., & Maher, L. (2013). From oxycodone to heroin: Two cases of transitioning opioid use in young Australians. *Drug and Alcohol Review*, 33, 102-104. doi: 10.1111/dar.12093
- Dingelstad, D., Gosden, R., Martin, B., & Vakas, N. (1996). The social construction of drug debates. *Social Science & Medicine*, 43(12).
- Dole, V., & Nyswander, M. (1967). Heroin Addiction - A Metabolic Disease. *Archives of Internal Medicine*, 120(1), 19-24.

- Douglas, R. M., & McDonald, D. N. (2012). *The prohibition of illicit drugs is killing and criminalising our children and we are all letting it happen*: Australia 21.
- Dow, C. M., Roche, P. A., & Ziebland, S. (2012). Talk of frustration in the narratives of people with chronic pain. *Chronic illness*, 8(3), 176-191.
- Dowbiggin, I. R. (2009). High anxieties: the social construction of anxiety disorders. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 54(7), 429-436.
- Dreisbach, R. H., & Pfeiffer, C. (1943). Caffeine Withdrawal Headache. *Journal of Laboratory Clinical Medicine*, 1219-1219.
- Drugs and Crime Prevention Committee. (2007). Inquiry Into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs in Victoria: Final Report: Parliament of Victoria.
- Duff, C. (2003). Drugs and Youth Cultures: Is Australia Experiencing the 'Normalization' of Adolescent Drug Use? *Journal of Youth Studies*, 6(4), 433-446.
- Duff, C. (2005). Party drugs and party people: examining the 'normalization' of recreational drug use in Melbourne, Australia. *International Journal of Drug Policy*, 16(3), 161-170. doi: <http://dx.doi.org/10.1016/j.drugpo.2005.02.001>
- Duff, E., & Lane, D. (2011, 6 March, 2011). Legal 'heroin' sold to addicts, *Sydney Morning Herald*. Retrieved from <http://www.smh.com.au/nsw/legal-heroin-sold-to-addicts-20110305-1bipy.html>
- Duster, T. S. (1970). *The Legislation of Morality: Law, Drugs, and Moral Judgment*. New York The Free Press.
- Dutch, M. J. (2008). Nurofen Plus misuse: an emerging cause of perforated gastric ulcer. *The Medical Journal of Australia*, 188(1), 56-57.
- Dyson, T. (1992). *Sexual behaviour and networking: anthropological and socio-cultural studies on the transmission of HIV*: Derouaux - Ordina.
- Dyster, B., & Meredith, D. (1990). *Australia in the International Economy: In the Twentieth Century*: Cambridge University Press.
- Edwards, M. (2008, 23 June). 'Hillbilly heroin' makes its mark on Australian streets, *Australian Broadcasting Corporation*. Retrieved from <http://www.abc.net.au/news/2008-06-23/hillbilly-heroin-makes-its-mark-on-australian/2480638>
- Ehrenreich, B., & English, D. (1973). *Complaints and Disorders: The Sexual Politics of Sickness*: Feminist Press.
- Ehrenreich, B., & English, D. (1978). *For her own good: 150 years of the experts' advice to women*: Anchor Press.
- Eisenberger, N. (2012). The pain of social disconnection: examining the shared neural underpinnings of physical and social pain. *Nature Reviews Neuroscience*, 13(6), 421-434.
- Eisenberger, N. I. (2011). The neural basis of social pain: Findings and implications. *Social pain: Neuropsychological and health implications of loss and exclusion*, 53-78.
- Eisenberger, N. I., & Lieberman, M. D. (2004). Why rejection hurts: a common neural alarm system for physical and social pain. *TRENDS in Cognitive Sciences*, 8(7), 294-300.

- Elliott, C., & Kramer, P. D. (2004). *Better Than Well: American Medicine Meets the American Dream*: W. W. Norton.
- Fazio, A., Joe-Laidler, K., Moloney, M., & Hunt, G. (2010). Gender, Sexuality, and Ethnicity as Factors of Club-Drug Use among Asian Americans. *Journal of Drug Issues, 40*(2), 405-432.
- Featherstone, M. (1982). The Body in Consumer Culture. *Theory, Culture & Society, 1*(2), 18-33.
- Feeley, M. (1992). *The Process is the Punishment: Handling Cases in a Lower Criminal Court*: Russell Sage Foundation.
- Ferlie, E., McGivern, G., & FitzGerald, L. (2012). A new mode of organizing in health care? Governmentality and managed networks in cancer services in England. *Social Science & Medicine, 74*(3), 340-347.
- Ferrell, B. A. (2003). Acute and Chronic Pain. In C. K. Cassel (Ed.), *Geriatric Medicine: An Evidence-Based Approach*: Springer.
- Ferrell, J., & Stewart-Huidobro, E. (1996). *Crimes of style: Urban graffiti and the politics of criminality*: Northeastern University Press Boston.
- Filmore, K. M., & Roizen, R. (2000). The new manichaeism in alcohol science. *Addiction, 95*(2), 188-189.
- Fischer, B., Turnbull, S., Poland, B., & Haydon, E. (2004). Drug use, risk and urban order: examining supervised injection sites (SISs) as 'governmentality'. *International Journal of Drug Policy, 15*(5-6), 357-365.
- Fischer, M. A., Stedman, M. R., Lii, J., Vogeli, C., Shrank, W. H., Brookhart, M. A., & Weissman, J. S. (2010). Primary medication non-adherence: analysis of 195,930 electronic prescriptions. *Journal of general internal medicine, 25*(4), 284-290.
- Fishbain, D. A., Cutler, R., Rosomoff, H. L., & Rosomoff, R. S. (1997). Chronic pain-associated depression: antecedent or consequence of chronic pain? A review. *The Clinical Journal of Pain, 13*(2), 116-137.
- Fisher, M. A. (2003). Physicians and the Pharmaceutical Industry: A Dysfunctional Relationship. *Perspectives in Biology and Medicine, 46*(2), 254-272.
- FitzGerald, J. L., Broad, S., Dare, A., & Foundation, V. H. P. (1999). *Regulating the Street Heroin Market in Fitzroy/Collingwood*: University of Melbourne, Department of Criminology.
- Fitzgerald, R., & Jordan, T. (2011). *Under the Influence: A History of Alcohol in Australia*: HarperCollins Publishers.
- Foddy, B., & Savulescu, J. (2010). A Liberal Account of Addiction. *Philosophy, Psychiatry & Psychology, 17*(1), 1-22.
- Fortney, J., Curran, S., Fortney, G., Xiaotong, S., Booth, H., & Mukherjee, B. (2004). Factors Associated With Perceived Stigma for Alcohol Use and Treatment Among At-Risk Drinkers. *Journal of Behavioral Health Services & Research, 31*(4), 418-429.
- Foucault, M. (1973). *The Birth of the Clinic: An Archaeology of Medical Perception*: Routledge.
- Foucault, M. (1980). Two Lectures (C. Gordon, L. Marshall, J. Mephram & K. Soper, Trans.). In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. New York: Pantheon Books.

- Foucault, M. (1988). *Madness and Civilisation: A History of Insanity in the Age of Reason* (R. Howard, Trans.). New York: Vintage Books.
- Foucault, M. (1994). *The Birth of the Clinic: An Archaeology of Medical Perception* (A. Sheridan, Trans.). New York: Vintage Books.
- Frampton, C. L., & Hughes-Webb, P. (2011). The Measurement of Pain. *Clinical Oncology*, 23(6), 381-386.
- Fraser, S. (2004). 'It's your life!': injecting drug users, individual responsibility and hepatitis C prevention. *Health*, 8(2), 199-221.
- Fraser, S. (2008). Trauma, damage and pleasure: Rethinking problematic drug use. *International Journal of Drug Policy*, 19(5), 410-416.
- Fraser, S., Hopwood, M., Treloar, C., & Brener, L. (2004). Needle fictions: Medical constructions of needle fixation and the injecting drug user. *Addiction Research & Theory*, 12(1), 67-76.
- Fraser, S., Moore, D., & Keane, H. (2014). *Habits: Remaking Addiction*: Palgrave Macmillan.
- Fraser, S., & Seear, K. (2013). *Making Disease, Making Citizens: The Politics of Hepatitis C*: Ashgate Publishing, Limited.
- Fraser, S., & Valentine, K. (2008). *Substance and substitution: methadone subjects in liberal societies*: Palgrave Macmillan.
- Freeman, K., Jones, C. G., Weatherburn, D. J., Rutter, S., Spooner, C. J., & Donnelly, N. (2005). The impact of the Sydney Medically Supervised Injecting Centre (MSIC) on crime. *Drug and Alcohol Review*, 24(2), 173-184.
- Freeman, R. B. (2002). The labour market in the new information economy. *Oxford Review of Economic Policy*, 18(3), 288-305.
- Freidson, E. (1988). *Profession of Medicine: A Study of the Sociology of Applied Knowledge*: University of Chicago Press.
- Friedman, J., & Alicea, M. (2001). *Surviving heroin: Interviews with women in methadone clinics*: University Press of Florida.
- Gahlinger, P. (2004). *Illegal Drugs: A Complete Guide to Their History, Chemistry, Use, and Abuse*: Plume Publications.
- Galea, S., Ahern, J., & Vlahov, D. (2003). Contextual determinants of drug use risk behavior: a theoretic framework. *Journal of Urban Health*, 80, iii50-iii58.
- Gault, M. H., Rudwal, T. C., Engles, W. D., & Dossetor, J. B. (1968). Syndrome associated with the abuse of analgesics. *Annals of Internal Medicine*, 68, 906-923.
- Germov, J. (2009). *Second Opinion: An Introduction to Health Sociology*: OUP Australia & New Zealand.
- Giddens, A. (1991). *Modernity and Self-identity: Self and Society in the Late Modern Age*: Stanford University Press.
- Giddings, D., Christo, G., & Davy, J. (2003). Reasons for Injecting and Not Injecting: a qualitative study to inform therapeutic intervention. *Drugs: education, prevention and policy*, 10(1), 95-104.
- Goffman, E. (1963). *Stigma: notes on the management of spoiled identity*: Prentice-Hall.
- Good, M. J. D. V., Brodwin, P. E., Good, B. J., & Kleinman, A. (1994). *Pain as Human Experience: An Anthropological Perspective*: University of California Press.

- Goverment, H. (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages: HM Government.
- Grau, L. E., Nabarun, D., Harvey, A. P., Irwin, K., Givens, A., Kinzly, M. L., & Robert, H. (2007). Illicit Use of Opioids: Is OxyContin® a "Gateway Drug"? *American Journal on Addictions, 16*(3), 166-173.
- Gray, G. C. (2009). The Responsibilization Strategy of Health and Safety Neoliberalism and the Reconfiguration of Individual Responsibility for Risk. *British Journal of Criminology, 49*(3), 326-342.
- Greene, J., & Hibbard, J. H. (2012). Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. *Journal of general internal medicine, 27*(5), 520-526.
- Gregg, M. (2011). *Work's Intimacy*: Wiley.
- Groves, A., & Marmo, M. (2009). How to 'Melt the Ice' on the Streets: A Social-Control Analysis on the Rise of Methamphetamine within Australia and the Need to Reduce Demand. *Current Issues in Criminal Justice, 20*(3), 413-432.
- Gureje, O., Korff, M. V., Simon, G., & Gater, R. (1998). Persistent Pain and Well-being: A World Health Organization Study in Primary Care. *Journal of the American Medical Association, 280*(2), 147-152.
- Hamilton, M., Kellehear, A., & Rumbold, G. (1998). *Drug Use in Australia: A Harm Minimisation Approach*: Oxford University Press.
- Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in Practice*: Taylor & Francis.
- Harkness, A. M. B., Long, B. C., Bermbach, N., Patterson, K., Jordan, S., & Kahn, H. (2005). Talking about work stress: Discourse analysis and implications for stress interventions. *Work & Stress, 19*(2), 121-136.
- Harris, G., Hodges, J. Q., & Snively, C. A. (2002). OxyContin in Missouri: A Policy Brief Exploring Patterns of Abuse *Prevention, Treatment and Interdiction Strategies*. University of Missouri, Columbia: Missouri Division of Alcohol and Drug Abuse.
- Harris, J., & McElrath, K. (2012). Methadone as Social Control Institutionalized Stigma and the Prospect of Recovery. *Qualitative Health Research, 22*(6), 810-824.
- Harrison, L., Kelly, P., Lindsay, J., Advocat, J., & Hickey, C. (2011). 'I don't know anyone that has two drinks a day': Young people, alcohol and the government of pleasure. *Health, Risk & Society, 13*(5), 469-486.
- Hartman, S. M. (1978). Prescriptions for Penelope. *Women's Studies, 5*(3), 223.
- Harvey, D. (2005). *A Brief History of Neoliberalism*: OUP Oxford.
- Hebdige, D. (1979). *Subculture: The Meaning of Style*: Methuen.
- Hendler, R. A., Ramchandani, V. A., Gilman, J., & Hommer, D. W. (2013). Stimulant and sedative effects of alcohol *Behavioral Neurobiology of Alcohol Addiction* (pp. 489-509): Springer.
- Hennessey, E. (1993). *A Cup of Tea, a Bex, and a Good Lie Down*: Department of History & Politics, James Cook University of North Queensland.
- Hennessey, E. M. (1992). 'Her Stand-by for Keeping Going' APC use during the boom decades. *Journal of the Royal Historical Society of Queensland, 15*(5), 248-264.

- Hobbs, D. (2003). *Bouncers: Violence and Governance in the Night-Time Economy*: Oxford University Press on Demand.
- Hogshire, J., & Alfvengren, S. (1999). *Pills-a-go-go: a fiendish investigation into pill marketing, art, history and consumption*: Feral House.
- Holdcroft, A., Smith, M., Jacklin, A., Hodgson, H., Smith, B., Newton, M., & Evans, F. (1997). Pain relief with oral cannabinoids in familial Mediterranean fever. *Anaesthesia*, 52(5), 483-486.
- Holloway, I., Sofaer-Bennett, B., & Walker, J. (2007). The stigmatisation of people with chronic back pain. *Disability & Rehabilitation*, 29(18), 1456-1464.
- Holt, M., & Treloar, C. (2008). Pleasure and drugs. *International Journal of Drug Policy*, 19(5), 349-352.
- Holyfield, L., & Fine, G. A. (1997). Adventure as character work: The collective taming of fear. *Symbolic Interaction*, 20(4), 343-363.
- Horkheimer, M., Adorno, T. W., & Noerr, G. S. (1944). *Dialectic of Enlightenment: Philosophical Fragments*.
- Hughes, J. (2008). *Pain Management: From Basics to Clinical Practice*: Elsevier.
- Hyman, S. E., & Malenka, R. C. (2001). Addiction and the brain: the neurobiology of compulsion and its persistence. *Nature Reviews Neuroscience*, 2(10), 695-703.
- Illich, I. (1976). *Medical Nemesis: The Expropriation of Health*: Pantheon Books.
- Illouz, E. (2013). *Why Love Hurts: A Sociological Explanation*: Wiley.
- Inciardi, J. A., & Harrison, L. D. (1999). *Harm Reduction: National and International Perspectives*: SAGE Publications.
- Inciardi, J. A., Surratt, H. L., Cicero, T. J., & Beard, R. A. (2009). Prescription opioid abuse and diversion in an urban community: the results of an ultrarapid assessment. *Pain Medicine*, 10(3), 537-548.
- International Association for the Study of Pain. (2014). IASP Taxonomy. Retrieved 29 March 2014, from <https://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1698>
- Iversen, L., & Chapman, V. (2002). Cannabinoids: a real prospect for pain relief. *Current Opinion in Pharmacology*, 2(1), 50-55. doi: [http://dx.doi.org/10.1016/S1471-4892\(01\)00120-5](http://dx.doi.org/10.1016/S1471-4892(01)00120-5)
- Jack S. Blocker, J., Fahey, D. M., & Tyrrell, I. R. (2003). *Alcohol and temperance in modern history: an international encyclopedia*: Abc-Clio Incorporated.
- Jackson, B. (1966). White-Collar Party. *Atlantic*, 218.
- Jackson, J. E. (2005). Stigma, liminality, and chronic pain: Mind-body borderlands. *American Ethnologist*, 32(3), 332-353.
- Jenkinson, R. A., Clark, N. C., Fry, C. L., & Dobbin, M. (2005). Buprenorphine diversion and injection in Melbourne, Australia: an emerging issue? *Addiction*, 100, 197-205.
- Johnson, E., & Åsberg, C. (2012). Enrolling Men, their Doctors, and Partners: Individual and Collective Responses to Erectile Dysfunction. *Science & Technology Studies*, 25(2).
- Jonas, L. M. (1999). Making and facing danger: Constructing strong character on the river. *Symbolic Interaction*, 22(3), 247-267.

- Kalso, E., Hearn, L., & de Williams, A. C. (2010). Reducing the risk of opioid misuse in persistent pain: Commentary on Jamison et al. *Pain*, 150(3), 375-376.
- Kaye, B. (2013). AMA repeats calls for DORA national roll-out. Retrieved 30 July, 2013, from <http://www.medicalobserver.com.au/news/ama-repeats-calls-for-dora-national-rollout>
- Keane, H. (2002). *What's Wrong With Addiction?* : Melbourne University Press.
- Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy*, 14, 227-232.
- Keane, H. (2011). Drugs that work: Pharmaceuticals and performance self-managment. In S. Fraser & D. Moore (Eds.), *The Drug Effect: Health, Crime and Society*: Cambridge University Press.
- Keane, H., & Hamill, K. (2010). Variations in Addiction: The Molecular and the Molar in Neuroscience and Pain Medicine. *BioSocieties*, 5(1), 52-69.
- Keane, H., Moore, D., & Fraser, S. (2011). Addiction and Dependence: Making Realities in the DSM. *Addiction*, 875-877.
- Kelly, B. C., & Parsons, J. T. (2007). Prescription Drug Misuse Among Club Drug-Using Young Adults. *The American Journal of Drug and Alcohol Abuse*, 33, 875-884.
- Kelly, P. J. (2005). Introduction: What is Liberalism? *Liberalism*: Polity.
- Kershner, R. M. (2008). Neuroadaptation and Multifocal IOLs. In D. F. Chang (Ed.), *Mastering Refractive IOLs: The Art and Science*: Slack.
- Kim, M., & Uhl, K. (2011). Sex and lifestyle drugs: The pursuit of the fountain of youth. *Clinical Pharmacology & Therapeutics*, 89(1), 3-9.
- Kincain-Smith, P. (1969). Analgesic Nephropathy: A common form of renal disease in Australia. *Med J Aust*, 2, 1131-1135.
- Kirsh, K. L., Jass, C., Bennett, D. S., Hagen, J. E., & Passik, S. D. (2007). Initial Development of a Survey Tool to Detect Issues of Chemical Coping in Chronic Pain Patients. *Palliative and Supportive Care*, 5, 219-226.
- Kolb, L. (1962). *Drug Addiction: A Medical Problem*. USA: Springfield, Illinois: Thomas Books.
- Kramer, P. D. (1994). *Listening to Prozac*. London: Penguin Books.
- Kwon, J. H., Tanco, K., Hui, D., Reddy, A., & Bruera, E. (2014). Chemical coping versus pseudoaddiction in patients with cancer pain. *Palliative and Supportive Care*, 1-5.
- Lake, M., & Reynolds, H. (2008). *Drawing the global colour line: white men's countries and the international challenge of racial equality*. Victoria: Cambridge University Press.
- Langellier, K., & Peterson, E. (2011). *Storytelling In Daily Life: Performing Narrative*: Temple University Press.
- Lankenau, S. E., Teti, M., Silva, K., Bloom, J. J., Harocopos, A., & Treese, M. (2012). Initiation into prescription opioid misuse amongst young injection drug users. *International Journal of Drug Policy*, 23(1), 37-44.
- Larance, B., Degenhardt, L., Lintzeris, N., Bell, J., Winstock, A., Dietze, P., . . . Horyniak, D. (2011). Post-marketing surveillance of buprenorphine-naloxone in Australia: Diversion, injection and adherence with supervised dosing. *Drug and Alcohol Dependence*, 118, 265-273.

- Larance, B., Degenhardt, L., Lintzeris, N., Winstock, A., & Mattick, R. (2011). Definitions related to the use of pharmaceutical opioids: Extramedical use, diversion, non-adherence and aberrant medication-related behaviours. *Drug and Alcohol Review, 30*, 236-245.
- Larner, W. (2000). Neo-liberalism: Policy, ideology, governmentality. *Studies in political economy, 63*.
- Law, J. (2004). *After Method: Mess in Social Science Research*: Routledge.
- Lenson, D. (1999). *On Drugs*: University of Minnesota Press.
- Leonard, K. E. (2002). Alcohol's role in domestic violence: a contributing cause or an excuse? *Acta Psychiatrica Scandinavica, 106*(s412), 9-14.
- Leshner, A. I. (1997). Addiction Is a Brain Disease, and It Matters. *Science, 278*(5335), 45-47. doi: 10.1126/science.278.5335.45
- Leshner, A. I. (2001). Addiction is a brain disease. *Issues in Science and Technology, 17*(3), 75-80.
- Levine, H. G. (1978). *The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America*.
- Levine, H. G. (1993). Temperance Cultures. In G. E. Malcolm Harold Lader, D. Colin Drummond (Ed.), *The Nature of Alcohol and Drug Related Problems*: Oxford University Press.
- Levine, H. G. (2003). Global drug prohibition: its uses and crises. *International Journal of Drug Policy, 14*(2), 145-153.
- Lewis, M. J., & MacPherson, K. L. (2007). Public health in Australia from the nineeenth to the twenty-first centry *Public Health in Asia and the Pacific: Historical and Comparative Perspectives*: Taylor & Francis.
- Lexchin, J. (2001). Lifestyle drugs: issues for debate. *Canadian Medical Association Journal, 164*(10), 1449-1451.
- Lindesmith, A. R. (1938). A sociological theory of drug addiction. *American Journal of Sociology, 5*, 593-613.
- Littlejohn, C., Baldacchino, A., & Bannister, J. (2004). Chronic Non-Cancer Pain and Opioid Dependence. *Journal of the Royal Society of Medicine, 97*, 62-65.
- Loxley, W. (2007). Benzodiazepine use and harms among police detainees in Australia *TRENDS & ISSUES in crime and criminal justice* (Vol. 336): Australian Institute of Criminology.
- Loxley, W., Chikritzhs, T., & Catalano, P. (2011). Stage Two Report 2011 - National Alcohol Sales Data Project: National Drug Research Institute & Drug and Alcohol Office, Government of Western Australia
- Loxley, W., Chikritzhs, T., & Pascal, R. (2009). Stage One Report 2009 - National Alcohol Sales Data Project: National Drug Research Institute & Drug and Alcohol Office, Government of Western Australia.
- Lupton, D. (1997). Foucault and the medicalisation critique. In R. Bunton & A. Petersen (Eds.), *Foucault, Health and Medicine*: Routledge.
- Lupton, D. (2012). *Medicine as Culture: Illness, Disease and the Body*: SAGE Publications.
- Lupton, D. (2013). The digitally engaged patient: self-monitoring and self-care in the digital health era. *Social Theory & Health, 11*(3), 256-270.
- Lupton, D. (2014). The pedagogy of disgust: the ethical, moral and political implications of using disgust in public health campaigns. *Critical Public Health*(ahead-of-print), 1-14.

- Lupton, G. M., & Najman, J. M. (1995). *Sociology of Health and Illness: Australian Readings*: Paul & Company Pub Consortium.
- Lyng, S. (1990). Edgework: A Social Psychological Analysis of Voluntary Risk Taking. *American Journal of Sociology*, 95(4), 851-886.
- Lyng, S. (2004). *Edgework: The Sociology of Risk-Taking*: Taylor & Francis.
- Lyon, J. (2009). *Pill Head: The Secret Life of a Painkiller Addict*. New York: Hyperion.
- MacDonald, G., & Leary, M. R. (2005). Why Does Social Exclusion Hurt? The Relationship Between Social and Physical Pain. *Psychological Bulletin*, 131(2), 202-223.
- Maher, L. (1997). *Sexed Work: Gender, Race, and Resistance in a Brooklyn Drug Market*. Clarendon Press: Oxford.
- Maher, L. (2000). *Sexed Work: Gender, Race and Resistance in a Brooklyn Drug Market*: Oxford University Press.
- Maher, L., & Dixon, D. (1999). Policing and Public Health: Law Enforcement and Harm Minimization in a Street-level Drug Market. *British Journal of Criminology*, 39(4), 488-512.
- Maher, L., & Dixon, D. (2001). Cost of Crackdowns: Policing Cabramatta's Heroin Market, The. *Current Issues Crim. Just.*, 13, 5.
- Makkai, T. (1999). Drug Use Monitoring in Australia: A Brief Description *Research and Public Policy Series No. 21*: Australian Institute of Criminology.
- Manderson, D. (1993). *From Mr Sin to Mr Big: A History of Australian Drug Laws*. Melbourne: Oxford University Press.
- Manderson, D. (1995). The semiotics of the Tittle: A comparative and historical analysis of drug legislation. *Law, Text, Culture*, 2, 160-178.
- Manderson, D. (2005). Possessed: Drug Policy, Witchcraft and Belief. *Cultural Studies*, 19(1).
- Marx, K. (1848). *The Communist Manifesto*.
- Matza, D. (1969). *Becoming deviant*: Prentice-Hall.
- McArthur, M. (1999a). *A History of Methadone Treatment in Australia: The Influence of Soical Control Arguments in its Development*. Paper presented at the History of Crime, Policing and Punishment Conference, Canberra.
- McArthur, M. (1999b). Pushing the drug debate: the media's role in policy reform. *Australian Journal of Social Issues*, 34(2).
- McClellan, D. S., Farabee, D., & Crouch, B. M. (1997). Early Victimization, Drug Use, and Criminality: A Comparison of Male and Female Prisoners. *Criminal Justice and Behavior*, 24(4), 455-476. doi: 10.1177/0093854897024004004
- McCreanor, T., Greenaway, A., Moewaka Barnes, H., Borell, S., & Gregory, A. (2005). Youth identity formation and contemporary alcohol marketing. *Critical Public Health*, 15(3), 251-262.
- McGregor, C., Gately, N., & Fleming, J. (2011). Prescription drug use among detainees: Prevalence, sources and links to crime *Trends & issues in crime and criminal justice No. 423, August 2011*: The Australian Institute of Criminology.
- Mckee, K. (2009). Post-Foucauldian governmentality: What does it offer critical social policy analysis? *Critical Social Policy*, 29(3), 465-486.

- Meares, T. L. (1997). Social organization and drug law enforcement. *American Criminal Law Review*, 35, 191.
- Measham, F., & Brain, K. (2005). 'Binge' drinking, British alcohol policy and the new culture of intoxication. *Crime, media, culture*, 1(3), 262-283.
- Measham, F., & Shiner, M. (2009). The legacy of 'normalisation': The role of classical and contemporary criminological theory in understanding young people's drug use. *International Journal of Drug Policy*, 20(6), 502-508.
- Meldrum, M. L. (2003). A capsule history of pain management. *Journal of the American Medical Association*, 290(18), 2470-2475.
- Melzack, R. (1975). The McGill Pain Questionnaire: Major properties and scoring methods. *Pain*, 1(3), 277-299.
- Melzack, R. (1996). *Gate control theory: On the evolution of pain concepts*. Paper presented at the Pain forum.
- Melzack, R., & Wall, P. D. (1967). Pain mechanisms: a new theory. *Survey of Anesthesiology*, 11(2), 89-90.
- Mendes, P. (2007). Fighting the Drugs War: The role of prohibitionist groups in Australian illicit drugs policy. *Practice Reflexions*, 2(1), 3-16.
- Miles, A. (1953, 25 October, 1953). Pills: Are they a help or a menace?, *Baltimore Afro-American*. Retrieved from <http://news.google.com/newspapers?nid=2205&dat=19551025&id=OYIAAAAIBA&sjid=cfUFAAAAIBA&pg=2329,1952799>
- Miller, F. P., Vandome, A. F., & McBrewster, J. (2009). *Classical Liberalism: Liberalism, Social Liberalism, Libertarianism, Freedom of Speech, Freedom of the Press, Freedom of Assembly, Laissez-faire, List of Liberal Theorists*: Alphascript Publishing.
- Miller, P., Pennay, A., Jenkinson, R., Droste, N., Chikritzhs, T., Tomsen, S., . . . Lubman, D. (2013). Patron offending and intoxication in night-time entertainment districts (POINTED): A study protocol. *International Journal of Alcohol and Drug Research*, 2(1).
- Miller, S. (2009). 'Chapter Four: Context of the National Strategy', *NDS Final Report Vol 1*, Department of Health and Aging.
- Moore, D. (1993). Beyond Zinberg's 'social setting': a processual view of illicit drug use. *Drug and Alcohol Review*, 12(4), 413-421.
- Moore, D. (2004). Governing street-based injecting drug users: a critique of heroin overdose prevention in Australia. *Social Science & Medicine*, 59(7), 1547-1557.
- Moore, D. (2008). Erasing pleasure from public discourse on illicit drugs: On the creation and reproduction of an absence. *International Journal of Drug Policy*, 19(5), 353-358.
- Moore, D. (2010). Beyond disorder, danger, incompetence and ignorance: Rethinking the youthful subject of alcohol and other drug policy. *Contemporary Drug Problems*, 37, 475-.
- Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science & Medicine*, 62(12), 3035-3047.
- Morgan, B. D. (2006). Knowing How to Play the Game: Hospitalized Substance Abusers' Strategies for Obtaining Pain Relief. *Pain Management Nursing*, 7(1), 31-41.

- Morris, D. B. (1991). *The Culture of Pain*. Oxford, England: University of California Press.
- Moynihan, R., Heath, I., & Henry, D. (2002). Selling sickness: the pharmaceutical industry and disease mongering. *British Medical Journal*, 324(7342), 886.
- Murray, R. (1980). Minor Analgesic Abuse: The Slow Recognition of a Public Health Problem. *BJA*, 75.
- Nadesan, M. H. (2008). *Governmentality, Biopower, and Everyday Life*: Routledge.
- National Drug and Alcohol Research Centre. (2013). Illicit Drug Reporting System. Retrieved December 12, 2012, from <http://ndarc.med.unsw.edu.au/project/illicit-drug-reporting-system-idrs>
- National Institute on Drug Abuse. (2007). Drugs, Brain and Behaviour: The Science of Addiction Retrieved 13 January, 2012, from <http://www.drugabuse.gov/sites/default/files/sciofadddiction.pdf>
- National Pain Summit Initiative. (2010). *National Pain Strategy: Pain Management for all Australians*: MBF Foundation & University of Sydney Pain Management Research Institute.
- Navarro, V. (2007). *Neoliberalism, globalization, and inequalities: Consequences for health and quality of life*: Baywood Pub.
- Ng, S., & Macgregor, S. (2012). Pharmaceutical drug use among police detainees *Research in Practice No. 23, February 2012*: The Australian Institute of Criminology.
- Nichter, M., Quintero, G., Nichter, M., Mock, J., & Shakib, S. (2004). Qualitative Research: Contributions to the Study of Drug Use, Drug Abuse, 1 and Drug Use (r)-Related Interventions. *Substance Use & Misuse*, 39(10-12), 1907-1969.
- Noble, B., Clark, D., Meldrum, M., ten Have, H., Seymour, J., Winslow, M., & Paz, S. (2005). The measurement of pain, 1945–2000. *Journal of Pain and Symptom Management*, 29(1), 14-21. doi: <http://dx.doi.org/10.1016/j.jpainsymman.2004.08.007>
- Northern Private Pain Centre. (2012). What is Chronic Pain? Retrieved 22 January, 2014, from <http://www.northernpaincentre.com.au/what-is-chronic-pain/w1/i1001394/>
- Nosyk, B., Guh, D. P., Bansback, N. J., Oviedo-Joekes, E., Brissette, S., Marsh, D. C., . . . Anis, A. H. (2012). Cost-effectiveness of diacetylmorphine versus methadone for chronic opioid dependence refractory to treatment. *Canadian Medical Association Journal*, 184(6), E317-E328.
- O'Malley, P. (2004). The uncertain promise of risk. *The Australian and New Zealand Journal of Criminology*, 37, 323-343.
- O'Toole, S., & Connect, P. (2013). *Habit in the English Novel, 1850-1900: Lived Environments, Practices of the Self*: Palgrave Macmillan.
- O'Hare, P. (2007). Merseyside, the first harm reduction conferences, and the early history of harm reduction. *International Journal of Drug Policy*, 18(2), 141-144.
- Palley, T. I. (2005). From Keynesianism to neoliberalism: Shifting paradigms in economics. *Neoliberalism: A critical reader*, 20-30.

- Panadol® Australia. (2012). Manage your pain. Retrieved March 22, 2012, from <https://www.panadol.com.au/?cid=SEM:Google:Products & Brand Exact:Brand - General&gclid=CJS92eS8uq8CFQcipAodJGfKiQ>
- Panksepp, J. (2003). Feeling the Pain of Social Loss. *Science*, 302, 237-239.
- Parham, D. (2012). Australia's Productivity Growth Slump: Signs of Crisis, Adjustment or Both? *Visiting Researcher Paper: Productivity Commission*, Australian Government.
- Parker, H. (1998). *Illegal Leisure: The Normalization of Adolescent Recreational Drug Use*: Taylor & Francis.
- Parker, H., & Williams, L. (2003). Intoxicated weekends: young adults' work hard-play hard lifestyles, public health and public disorder. *Drugs: education, prevention, and policy*, 10(4), 345-367.
- Parsons, T. (1951). Illness and the role of the physician: a sociological perspective. *American Journal of orthopsychiatry*, 21(3), 452-460.
- Passik, S. D., & Kirsh, K. L. (2004). Assessing Aberrant Drug-Taking Behaviors in the Patient with Chronic pain. *Current Pain and Headache Reports*, 8(4), 289-294.
- Passik, S. D., Kirsh, K. L., & Webster, L. (2011). Pseudoaddiction revisited: a commentary on clinical and historical considerations. *Pain management*, 1(3), 239-248.
- Pat O'Malley, L. W., & Clifford, S. (1997). Governmentality, criticism, polities. *Economy and Society*, 26(4), 501-217.
- Pearson, G. (1975). *The deviant imagination: Psychiatry, social work, and social change*: Macmillan London.
- Petersen, A. (1997). Risk, governance and the new public health. In R. Bunton & A. Petersen (Eds.), *Foucault, Health and Medicine*: Routledge.
- Petersen, A., Davis, M., Fraser, S., & Lindsay, J. (2010). Healthy living and citizenship: an overview. *Critical Public Health*, 20(4), 391-400.
- Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk*: Sage Publications, Inc.
- Pharmacy Guild of Australia, T. (2007). Project STOP. Retrieved 17 Aug, 2011, from www.projectstop.com.au/
- Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: the case of mental illness. *Journal of Health and Social Behavior*, 46(4), 307-322.
- Phillips, W. (1980). 'Six o'clock swill': The introduction of early closing of hotel bars in Australia. *Historical Studies*, 19(75), 250-266. doi: 10.1080/10314618008595637
- Portenoy, R. K., & Foley, K. M. (1986). Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases. *Pain*, 25(2), 171-186.
- Post, R. M. (2002). Do the epilepsies, pain syndromes, and affective disorders share common kindling-like mechanisms? *Epilepsy Research*, 50(1-2), 203-219.
- Poynting, S., & Morgan, G. (2007). *Outrageous!: Moral Panics in Australia*: Australian Clearinghouse for Youth Studies.
- Pradel, V., Delga, C., Rouby, F., Micallef, J., & Lapeyre-Mestre, M. (2010). Assessment of abuse potential of benzodiazepines from a prescription

- database using 'doctor shopping' as an indicator. *CNS drugs*, 24(7), 611-620.
- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. No health without mental health. *The Lancet*, 370(9590), 859-877. doi: 10.1016/s0140-6736(07)61238-0
- Punch, M. (2005). Problem drug use and the political economy of urban restructuring: heroin, class and governance in Dublin. *Antipode*, 37(4), 754-774.
- Purdie, N., Dudgeon, P., & Walker, R. (2010). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. In D. o. H. a. Aging (Ed.): Australian Government.
- Race, K. (2005). Recreational states: Drugs and the sovereignty of consumption. *Culture Machine*, 7(Special issue on biopolitics).
- Race, K. (2009). *Pleasure Consuming Medicine: The Queer Politics of Drugs*: Duke University Press.
- Ray, M. B. (1961). The cycle of abstinence and relapse among heroin addicts. *Social Problems*, 132-140.
- Ray, O. S. (1978). *Drugs, Society, and Human Behavior*. St. Louis: C. V. Mosby Co.
- Reckitt Benckiser (Australia) Pty Limited. (2010). Nurofen Pain Relief Advice - Expert info on migraines, headaches, back pain, toothache and more - targeted pain relief with ibuprofen. Retrieved March 22, 2012, from http://www.nurofen.com.au/pain-relief/videos/video_player.php?filename=Wedding_Stress.flv&title=Nurofen&transcript=na.pdf
- Redfield, M., & Brodie, J. F. (2002). Introduction. In Janet Farrell & M. Redfield (Eds.), *High Anxieties: Cultural Studies in Addiction*: University of California Press.
- Redonnet, B., Chollet, A., Fombonne, E., Bowes, L., & Melchior, M. (2012). Tobacco, alcohol, cannabis and other illegal drug use among young adults: The socioeconomic context. *Drug and Alcohol Dependence*, 121(3), 231-239.
- Reidenberg, M., & Willis, O. (2007). Prosecution of physicians for prescribing opioids to patients. *Clinical Pharmacology & Therapeutics*, 81(6), 903-906.
- Reiner, R. (2012). What's Left? The prospects for social democratic criminology. *Crime, media, culture*, 8(2), 135-150. doi: 10.1177/1741659012444434
- Reith, G. (2004). On the Edge: Drugs and the Consumption of Risk in Late Modernity. In S. Lyng (Ed.), *Edgework: The Sociology of Risk-Taking*: Taylor & Francis.
- Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, 13(2), 85-94.
- Rhodes, T., Briggs, D., Kimber, J., Jones, S., & Holloway, G. (2007). Crack-heroin speedball injection and its implications for vein care: qualitative study. *Addiction*, 102(11), 1782-1790.
- Rhodes, T., & Moore, D. (2001). On the qualitative in drugs research: Part one. *Addiction Research & Theory*, 9(4), 279-297.

- Rhodes, T., Singer, M., Bourgois, P., Friedman, S. R., & Strathdee, S. A. (2005). The social structural production of HIV risk among injecting drug users. *Social Science & Medicine*, 61(5), 1026-1044.
- Ritter, A. (2007). Methamphetamine alarm: are we forgetting what we know? *Drug and Alcohol Review*, 26(3), 227-230.
- Ritter, A., & Natale, R. D. (2005). The relationship between take-away methadone policies and methadone diversion. *Drug and Alcohol Review*, 24, 347-352.
- Ritzer, G. (2001). *Explorations in the Sociology of Consumption: Fast Food, Credit Cards and Casinos*: SAGE Publications.
- Ritzer, G. (2005). *Enchanting a disenchanted world: revolutionizing the means of consumption*: Pine Forge Press.
- Ritzer, G. (2014). *The McDonaldization of Society*: SAGE Publications.
- Robson, P. (2009). *Forbidden Drugs*: OUP Oxford.
- Rodwell, L., Ringland, C., & Bradford, D. (2010). What do police data tell us about criminal methods of obtaining prescription drugs? *Contemporary Issues in Crime and Justice*, 139, 1-12.
- Rolfe, J. L. (1989). Legal Alternatives and Consequences. Historical Paper: Legislative Developments. Melbourne: Drug Research & Rehabilitation Fund.
- Rollins, A. (2015). National system urgently needed to counter doctor shopping, drug deaths. 2015, from <https://ama.com.au/ausmed/national-system-urgently-needed-counter-doctor-shopping-drug-deaths>
- Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, 24(2), 143-155.
- Room, R. (2010). The long reaction against the wowser: The prehistory of alcohol deregulation in Australia. *Health Sociology Review*, 19(2), 151-163.
- Rose, N. (2003). The neurochemical self and its anomalies. In R. V. Ericson & A. Doyle (Eds.), *Risk and Morality*. Toronto: University of Toronto Press.
- Rose, N. (2009). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*: Princeton University Press.
- Rowe, J. (2005). From Deviant to Disenfranchised: The evolution of drug users in AJSI. *Australian Journal of Social Issues*, 40(1), 107-123.
- Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data*: Sage Publications.
- Salecl, R. (2004). *On Anxiety*: Routledge.
- Sanders, B. (2012). Gang youth, substance use patterns, and drug normalization. *Journal of Youth Studies*, 1-17.
- Saukko, P. (2003). *Doing Research in Cultural Studies: An Introduction to Classical and New Methodological Approaches*. London: SAGE.
- Scarry, E. (1985). *The body in pain: the making and unmaking of the world*: Oxford University Press.
- Science, A. A. o. (2003). 'Interview with Professor Kincaid Smith'. [Online] Available: www.science.org.au/scientistspks.htm [accessed March 11, 2011].

- Searight, H. R., & McLaren, A. L. (1998). Attention-deficit hyperactivity disorder: The medicalization of misbehavior. *Journal of Clinical Psychology in Medical Settings*, 5(4), 467-495.
- Sedgwick, E. K. (1993). *Epidemics of the will Tendencies*. London: Routledge.
- Sees, K., Di Marino, M. E., Ruediger, N. K., Sweeney, C. T., & Shiffman, S. (2005). Non-Medical Use of OxyContin Tablets in the United States. *Journal of pain & palliative care pharmacotherapy*, 19(2), 13-23.
- Selye, H. (1954). *The Physiology and Pathology of Exposure to Stress; a Treatise Based on the Concepts of the General-adaptation-syndrome and the Diseases of Adaptation: Annual report on stress*: Acta.
- Selye, H. (1956). *The stress of life*.
- Selye, H. (1977). *The Stress of My Life: A scientist's memoirs*: McClelland and Stewart Toronto.
- Shacham, E., & Cottler, L. (2010). Sexual Behaviors among Club Drug Users: Prevalence and Reliability. *Archives of Sexual Behavior*, 39(6), 1331-1341.
- Shelley, J. H. (1967). Phenacetin through the looking glass. *Clinical Pharmacology and Therapeutics*, 8, 427-371.
- Sherman, S. G., Smith, L., Laney, G., & Strathdee, S. A. (2002). Social influences on the transition to injection drug use among young heroin sniffers: a qualitative analysis. *International Journal of Drug Policy*, 13(2), 113-120.
- Shildrick, T. (2002). Young People, Illicit Drug Use and the Question of Normalization. *Journal of Youth Studies*, 5(1), 35-48.
- Shorter, E., & Marshall, J. C. (1997). A history of psychiatry. *Nature*, 386(6623), 346-346.
- Silverman, D. (1985). *Qualitative methodology and sociology: describing the social world*: Gower Publishing Corporation.
- Silverman, D. (2013). *Doing Qualitative Research: A Practical Handbook*: SAGE Publications.
- Singer, M. (2008). Drugs and development: the global impact of drug use and trafficking on social and economic development. *International Journal of Drug Policy*, 19(6), 467-478.
- Smith, C. B. (2011). A Users' Guide to 'Juice Bars' and 'Liquid Handcuffs' Fluid Negotiations of Subjectivity, Space and the Substance of Methadone Treatment. *Space and Culture*, 14(3), 291-309.
- Smith, D. A., & Visher, C. A. (1981). Street-Level Justice: Situational Determinants of Police Arrest Decisions. *Social Problems*, 29(2), 167-177.
- Smith, P., & Morton, G. (2006). Nine years of new labour: neoliberalism and workers' rights. *British Journal of Industrial Relations*, 44(3), 401-420.
- Speaker, S. L. (1997). From "happiness pills" to "national nightmare": changing cultural assessment of minor tranquilizers in America, 1955-1980. *Journal of the history of medicine and allied sciences*, 52(3), 338-376.
- Sporer, K. A., & Kral, A. H. (2007). Prescription naloxone: a novel approach to heroin overdose prevention. *Annals of Emergency Medicine*, 49(2), 172-177.

- Stafford, J., & Burns, L. (2009). Australian Drug Trends 2009: Findings from the Illicit Drug Reporting System *Australian Drug Trends Series No. 37*: National Drug and Alcohol Research Centre.
- Stafford, J., & Burns, L. (2010). Australian Drug Trends 2010: Findings of the Illicit Drug Reporting System and the Ecstasy and Related Drugs Reporting System *Australian Drug Trends Series No. 55*: National Drug and Alcohol Research Centre.
- Stafford, J., & Burns, L. (2011). Australian Drug Trends: Findings from the Illicit Drug Reporting System *Australian Drug Trends Series No. 73*: National Drug and Alcohol Research Centre.
- Stafford, J., & Burns, L. (2012). Australian Drug Trends: Findings from the Illicit Drug Reporting System *Australian Drug Trends Series No. 91* National Drug and Alcohol Research Centre.
- State Government of Victoria. (2013). Wellbeing. Retrieved October 4, 2013, from www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/wellbeing?open
- Stein, M. (2009). *The Addict: One Patient, One Doctor, One Year*. New York: HarperCollins.
- Stelle, T. W., Gyory, A. Z., & Edwards, K. D. G. (1969). Renal Function in Analgesic Nephropathy. *British Medical Journal*, 2, 213-216.
- Steptoe A, Peacey V, & Wardle J. (2006). Sleep duration and health in young adults. *Archives of Internal Medicine*, 166(16), 1689-1692. doi: 10.1001/archinte.166.16.1689
- Steward, W. T., Herek, G. M., Ramakrishna, J., Bharat, S., Chandy, S., Wrubel, J., & Ekstrand, M. L. (2008). HIV-related stigma: adapting a theoretical framework for use in India. *Social Science & Medicine*, 67(8), 1225-1235.
- Stewart, H. H. (1978). Analgesic Abuse and Renal Failure in Australasia. *Kidney International*, 13, 72-78.
- Stoelting, R. K., & Hillier, S. C. (2012). *Pharmacology and Physiology in Anesthetic Practice*: Wolters Kluwer Health.
- Strong, P. M. (1979). *The Ceremonial Order of the Clinic: Parents, Doctors, and Medical Bureaucracies*: Routledge & Kegan Paul.
- Sulkunen, P. (2002). Between culture and nature: Intoxication in cultural studies of alcohol and drug use. *Contemp. Drug Probs.*, 29, 253.
- Sulkunen, P., & Warpenius, K. (2000). Reforming the self and the other: The temperance movement and the duality of modern subjectivity. *Critical Public Health*, 10(4), 423-438.
- Sweeney, J., & Payne, J. (2012). Drug use monitoring in Australia: 2009-10 report on drug use among police detainees *AIC Reports: Monitoring Reports 17*: Australian Institute of Criminology.
- Szasz, T. S. (1961). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*: HarperCollins Publishers.
- Szasz, T. S. (1970). *The Manufacture Of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*: Delta Book.
- Szmigin, I., Griffin, C., Mistral, W., Bengry-Howell, A., Weale, L., & Hackley, C. (2008). Re-framing 'binge drinking' as calculated hedonism: Empirical

- evidence from the UK. *International Journal of Drug Policy*, 19(5), 359-366.
- Taylor, I., Walton, P., & Young, J. (1973). *The New Criminology: For a Social Theory of Deviance*: Taylor & Francis.
- Teesson, M., Mitchell, P. B., Deady, M., Memedovic, S., Slade, T., & Baillie, A. (2011). Affective and anxiety disorders and their relationship with chronic physical conditions in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry*, 45, 939-946.
- Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine*, 69(1), 28-35. doi: <http://dx.doi.org/10.1016/j.socscimed.2009.03.037>
- Telegraph, T. D. (2014, 7 June 2014). Poverty-stricken pensioners turn to drug dealing for cash, *The Daily Telegraph*.
- The Royal Australasian College of Physicians. (2009). Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use.
- Tomsen, S. (2003). Bouncers: Violence and Governance in the Night-time Economy. *Current Issues in Criminal Justice*, 15(2), 200.
- Tomsen, S., Homel, R., & Thommeny, J. (1990). Situational Factors in Alcohol-Related Public Assaults: National Committee on Violence/National Drug Offensive.
- Topp, L., Degenhardt, L., Kaye, S., & Darke, S. (2002). The emergence of potent forms of methamphetamine in Sydney, Australia: a case study of the IDRS as a strategic early warning system. *Drug and Alcohol Review*, 21(4), 341-348.
- Tracey, I., & Bushnell, M. C. (2009). How Neuroimaging Studies Have Challenged Us to Rethink: Is Chronic Pain a Disease? *The Journal of Pain*, 10(11), 1113-1120. doi: 10.1016/j.jpain.2009.09.001
- Treloar, C., & Holt, M. (2006). Deficit models and divergent philosophies: Service providers' perspectives on barriers and incentives to drug treatment. *Drugs: education, prevention, and policy*, 13(4), 367-382.
- Tunnell, K. D. (2005). The OxyContin epidemic and crime panic in rural Kentucky. *Contemporary Drug Problems*, 32(2), 225-258, 169-170.
- Turner, B. S. (1984). *The Body and Society: Explorations in Social Theory*: B. Blackwell.
- Turner, B. S. (2008). *The Body and Society: Explorations in Social Theory*: SAGE Publications.
- United Nations Office on Drugs and Crime. (2008). Drug Policy and Results in Australia *October 2008*.
- van Beek, I., Kimber, J., Dakin, A., & Gilmour, S. (2004). The Sydney Medically Supervised Injecting Centre: reducing harm associated with heroin overdose. *Critical Public Health*, 14(4), 391-406. doi: 10.1080/09581590400027528
- Van de Werf, F., Ardissino, D., Betriu, A., Cokkinos, D. V., Falk, E., Fox, K. A., . . . Ruzyllo, W. (2003). Management of acute myocardial infarction in patients presenting with ST-segment elevation. *European heart journal*, 24(1), 28-66.

- visit4ads. (2012). Pain Relief with Body Respect Advert, Ad - Panadol Range - Video Clip. from <http://www.visit4ads.com/advert/Pain-Relief-with-Body-Respect-Panadol-Range/91500>
- Vivian, J., Saleheen, H., Singer, M., Navarro, J., & Mirhej, G. (2005). Under the Counter: The Diffusion of Narcotic Analgesics to the Inner City Street. *Journal of Ethnicity in Substance Abuse, 4*(2), 971-114.
- Volkow, N. D., Fowler, J. S., Wang, G.-J., & Swanson, J. M. (2004). Dopamine in drug abuse and addiction: results from imaging studies and treatment implications. *Molecular psychiatry, 9*(6), 557-569.
- Vrecko, S. (2010). Birth of a brain disease: science, the state and addiction neuropolitics. *History of the Human Sciences, 23*(4), 52-67. doi: 10.1177/0952695110371598
- Wager, T. D., Atlas, L. Y., Lindquist, M. A., Roy, M., Woo, C.-W., & Kross, E. (2013). An fMRI-based neurologic signature of physical pain. *New England Journal of Medicine, 368*(15), 1388-1397.
- Wainwright, D., & Calnan, M. (2000). Rethinking the work stress 'epidemic'. *The European Journal of Public Health, 10*(3), 231-233. doi: 10.1093/eurpub/10.3.231
- Wardlaw, G., & Deane, H. (1986). Uses and abuses of drug law enforcement statistics. *Trends and issues in crime and criminal justice*(1).
- Wazana, A. (2000). Physicians and the pharmaceutical industry: Is a gift ever just a gift? *JAMA, 283*(3), 373-380. doi: 10.1001/jama.283.3.373
- Weatherburn, D. J. (2008). The role of drug and alcohol policy in reducing Indigenous over-representation in prison*. *Drug and Alcohol Review, 27*(1), 91-94. doi: 10.1080/09595230701710811
- Webster, L. R., & Webster, R. M. (2005). Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool. *Pain Medicine, 6*(6), 432-442.
- Weinberg, D. (1997). Lindesmith on addiction: A critical history of a classic theory. *Sociological theory, 15*(2), 150-161.
- Weinberg, D. (2011). Sociological perspectives on addiction. *Sociology Compass, 5*(4), 298-310.
- Wengraf, T. (2001). *Qualitative Research Interviewing: Biographic Narrative and Semi-Structured Methods*. London, Thousand Oaks & New Delhi: SAGE.
- Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Social Science & Medicine, 57*(8), 1409-1419.
- Whelan, E., Asbridge, M., & Haydt, S. (2011). Representations of OxyContin in North American newspapers and medical journals. *Pain Research & Management, 16*(4).
- Wilkinson, R. G., Marmot, G., & Europe, W. H. O. R. O. f. (2003). *Social Determinants of Health: The Solid Facts*: World Health Organization, Regional Office for Europe.
- Williams, S. J., Gabe, J., & Davis, P. (2008). The sociology of pharmaceuticals: progress and prospects. *Sociology of Health & Illness, 30*(6), 813-824. doi: 10.1111/j.1467-9566.2008.01123.x
- Williams, S. J., Gabe, J., & Davis, P. (2009). *Pharmaceuticals and Society: Critical Discourses and Debates*: John Wiley & Sons.

- Willis, E. (1989). *Medical Dominance: The Division of Labour in Australian Health Care* (revised ed.): Allen & Unwin.
- Wingood, G. M., DiClemente, R. J., & Raj, A. (2000). Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. *American journal of preventive medicine*, 19(4), 270-275.
- Winstock, A. R., & Lea, T. (2010). Diversion and Injection of Methadone and Buprenorphine Among Clients in Public Opioid Treatment Clinics in New South Wales, Australia. *Substance Use & Misuse*, 45(1-2), 240-252.
- Winstock, A. R., Lea, T., & Sheridan, J. (2007). Prevalence of diversion and injection of methadone and buprenorphine among clients receiving opioid treatment at community pharmacies in New South Wales, Australia. *International Journal of Drug Policy*, 19, 450-458.
- Wodak, A., & Cooney, A. (2005). Effectiveness of sterile needle and syringe programmes. *International Journal of Drug Policy*, 16, Supplement 1(0), 31-44.
- Wodak, A., & Owens, R. (1996). *Drug Prohibition: A Call for Change*: UNSW Press.
- Wodak, A., & Saunders, B. (1995). Harm reduction means what I choose it to mean. *Drug and Alcohol Review*, 14(3), 269-271.
- Wolf, E. S. (2002). *Treating the Self: Elements of Clinical Self Psychology*: Guilford Press.
- Woolhouse, M., Day, K., Rickett, B., & Milnes, K. (2012). 'Cos girls aren't supposed to eat like pigs are they?' Young women negotiating gendered discursive constructions of food and eating. *Journal of health psychology*, 17(1), 46-56.
- Workman, T. (2009). To the edge and back again: Edgework and collegiate drug use. *COLLEGIATE DRUG USE: A NEW LOOK AT AN OLD ISSUE*, 24.
- World Health Organisation. (2013). International Classification of Diseases (ICD). Retrieved June 4, 2011, from <http://www.who.int/classifications/icd/en/>
- World Health Organisation. (2014). WHO definition of health. Retrieved 10 September, 2014, from <http://www.who.int/about/definition/en/print.html>
- Young, J. (1971). *The Drugtakers: The social meaning of drug use*: MacGibbon and Kee.
- Young, J. (2011). Moral panics and the transgressive other. *Crime, media, culture*, 7(3), 245-258.
- Zibbell, J. E. (2004). Can the lunatics actually take over the asylum?: Reconfiguring subjectivity and neo-liberal governance in contemporary British drug treatment policy. *International Journal of Drug Policy*, 15(1), 56-65.
- Zimmerli, W. (2010). Vertebral osteomyelitis. *New England Journal of Medicine*, 362(11), 1022-1029.
- Zinberg, N. E. (1986). *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use*.