

**Faculty of Health Sciences  
National Drug Research Institute**

**Enacting heavy sessional drinking: a multi-sited ethnographic  
study of young adults' drinking events and related epidemiology,  
policy and treatment**

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**This thesis is presented for the Degree of  
Doctor of Philosophy  
of  
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**Declaration**

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature:.....*Naon Hart*.....

Date:....27/03/2016.....



## **Preface**

Some of the data and analysis presented in this thesis has already been published in scholarly journals. The first article arising from my PhD research was:

Hart, A., & Moore, D. (2014). Alcohol and alcohol effects: Constituting causality in alcohol epidemiology. *Contemporary Drug Problems*, 41(2).

My primary supervisor David Moore contributed to this article by reviewing drafts, contributing some commentary on international literature and crafting the conclusions. The critiques of two anonymous reviewers and Nancy Campbell's editorial comments also improved this article, and Carol Bacchi reviewed a version of this paper that I presented at a thematic meeting of the Kettil Bruun Society in Melbourne, 8–11 September 2014. Sections of the article, including those improved by the suggestions of each of these people, are presented in Chapter 5.

The second article arising from my PhD research was:

Hart, A. (2015). Assembling interrelations between low socioeconomic status and acute alcohol-related harms among young adult drinkers. *Contemporary Drug Problems*, 42(2).

I revised this article substantially after receiving anonymous reviews from three reviewers and editorial comments from Robin Room and Amy Pennay. Sections of the article, including the improvements resulting from these revisions, are presented in Chapter 6 and Chapter 7.

The third article arising from my PhD research was:

Hart, A. (2016). Good Sports, drinking cultures and hegemonic masculinities in a community sporting club case study. *Drugs: Education, Prevention and Policy*, early online

Anonymous reviewers and journal editor Amy Pennay suggested minor revisions to this article. Material including these improvements appears in Chapter 7.

Finally, the data and analysis for this thesis has informed publications led by other authors. These publications are:

Scott, N., Livingston, M., Hart, A., Wilson, J., Moore, D., & Dietze, P. (2016).

SimDrink: An agent-based netlogo model of young, heavy drinkers for conducting alcohol policy experiments. *Journal of Artificial Societies and Social Simulation*, early online

Scott, N., Hart, A. Wilson, J., Livingston, M., Moore, D., & Dietze P. The effects of extended public transport operating hours and venue lockout policies on drinking-related harms in Melbourne, Australia: Results from SimDrink, an agent-based simulation model. *International Journal of Drug Policy*, in press

Murphy, D. A., Hart, A., & Moore, D. Shouting and providing: Exchange in the drinking accounts of young people. *Drug and Alcohol Review*, minor revisions

No changes to this thesis were made as a result of the development of these publications.







# Abstract

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When harms emerge from young adults' heavy sessional drinking events, many causal explanations are possible. Each articulation of these problems identifies some of the entities involved with harm, while others are absent from the account. As policy and service responses are designed to intervene in the causes of alcohol-related harm, these articulations have important political effects. In this thesis, I analyse three influential disciplinary understandings of heavy sessional drinking: alcohol epidemiology concerned with morbidity and mortality; policy documents concerned with 'drinking cultures'; and clinical science informing the treatment of alcohol and other drug (AOD) problems. Using techniques from science and technology studies (STS), I unpack the respective theoretical and ontological precepts of these accounts and their political effects. While it is recognised that each of these approaches has its own explanatory power, I argue that each is partial, methodologically mediated and freighted with vested interests; each identifies a small number of causes, while exempting many others. In particular, I argue that the currently dominant approaches have achieved insufficient insight into the causal nexus of low socioeconomic status and alcohol-related harm, while at the same time presenting evidence of strong associations between the two. As counterpoints to the three disciplinary approaches studied, I use a different causal model to study the origins of alcohol-related harms—the causal assemblage—and argue that this approach disrupts the others by bringing an array of new entities into the causal frame and expanding the range of plausible policy and service responses. I demonstrate that this model is particularly well suited to identifying interrelations between various aspects of social and economic disadvantage and exposure to alcohol-related harms.

This research was designed as a multi-sited ethnography. I theoretically construct an ethnographic field comprising the three disciplinary sites and three counterpoising sites drawn from qualitative data gathered within the Melbourne suburb of Broadmeadows. Data on the disciplinary sites are drawn from scholarly literature,

government policy documents, and clinical practices and instruments employed in an AOD treatment clinic. The qualitative data gathered in Broadmeadows derive from interviews with 16 young adult heavy sessional drinkers, interviews with 15 professionals or volunteers who handle young adult heavy drinkers in some way, and approximately 45,000 words of observational field notes. My analyses of the disciplinary sites employ techniques from STS; these include rubrics for following controversies, describing different modes of ordering realities and deconstructing choreographies of practice. My analyses of the qualitative data is epistemologically grounded in specific drinking events and uses qualitative techniques to trace the ways in which drinking settings and the objects within them intersect with norms, histories and symbolic orders to transform the effects of alcohol, sometimes in harmful ways.

My analyses demonstrate that dominant disciplines tend to take heavy alcohol consumptions as a proxy for harm, erasing the complex transformations of alcohol effects wrought by the socio-material circumstances of drinking events. In contrast, I identify a wide array of actors, actants and practices that played causal roles in harmful events. These included: family and ethnic patterns of relations to alcohol and associated memories; gender norms and other rules enforced in public spaces; access to housing; systems of exchange and their co-constituting temporal horizons; takeaway alcohol products and their use within in a football ground car park; a football club history and the reproduction of modes of masculinity within it; and the difficult interpersonal, affective, financial and material circumstances experienced by young adults receiving AOD treatment.

In deploying this causal model and foregrounding the interrelated roles these entities played, my research represents a step towards positive outcomes. First, my thesis offers a novel critique—a departure from the existing body of qualitative studies of young adult heavy sessional drinking. Second, it suggests new directions for addressing alcohol-related harm through alcohol epidemiology, policies to change drinking cultures, and clinical AOD services. Finally, it contributes to the growing body of STS-informed AOD research and provides a novel example of applying these techniques within the field of alcohol studies.

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# Acknowledgments

Many of the arguments in this thesis emphasise the co-production of effects by a wider array of actors, actants and forces than are typically attributed with agency. My PhD is also a co-production, and in the spirit of broad attribution, this section details some of the roles played by its co-producers.

The National Drug Research Institute (NDRI) at Curtin University proved an enabling institutional setting for my work. An Australian Research Council Discovery Project (DP110101720)—led by David Moore and Paul Dietze, and administered through Curtin University—provided me with a PhD scholarship to cover some of my living expenses. I would like to thank Steve Allsop for his work in leading NDRI and Fran Davis, Jo Hawkins and Paul Jones for their administrative and IT support.

The academic staff at NDRI in Melbourne have provided a steady supply of intellectual coaching, collegial friendship and exemplary work from which to draw. Perhaps most importantly, they have provided me with a sense of what it is to take critical AOD research as a vocation. Monica Barratt, Cameron Duff, Robyn Dwyer, Suzanne Fraser, Peter Higgs, Elizabeth Manton, David Moore, Dean Murphy, Kiran Pienaar and Kate Seear have each contributed in these ways.

During my time at the Institute, NDRI Melbourne was co-located in Fitzroy with Turning Point Alcohol and Drug Centre and the Centre for Alcohol Policy Research. This environment was advantageous as it gave me direct access to a number of researchers whose writing and expertise were germane to my project. With a chance meeting in the lunch room or a visit to a desk, I could direct a query to the author of the work I was reading, or seek advice on a particular topic. My enquiries were always given generous time and consideration, and I was made to feel welcome within the research community. My thanks go to Ramez Bathish, Sarah Callinan, Jason Jiang, Anne-Marie Laslett, Michael Livingston, Sarah MacLean, Amy Pennay, Robin Room, Michael Savic and Claire Wilkinson.

Among the most enjoyable aspects of my postgraduate journey has been my association with a vibrant postgraduate cohort. My journey would have been much more arduous without the opportunity to discuss theory, receive suggestions on specific literature, or debrief after a data gathering venture or supervisory review. Many of my analytic breakthrough moments would not have been possible without my connection into this network of enquiring minds. The daily struggles of postgrad life were greatly leavened by their support, and Friday nights at the Standard Hotel with my postgrad friends were a welcome relief from the rigours of an academic week. My special thanks go to Monica Barratt, Frederik Bøhling, Ella Dilkes-Frayne, Adrian Farrugia, Renae Fomiatti, Elizabeth Normand, Merete Poulsen, Eliana Sarmiento Guerra and James Wilson.

The fieldwork in Broadmeadows was a defining feature of my postgraduate experience. The people I met there, and their stories, life circumstances and support for one another, form the political *raison d'être* of this work. It is only through their generosity that I was able to gather the empirical data I present here. My thanks go to the employees and volunteers with social service agencies and community groups, and the young people who I interviewed. While I cannot name them all for reasons of anonymity, Jaime de Loma-Osorio Ricon agreed to be named and deserves a special mention. Jaime's friendship, interest in my research, and deep commitment to the local community were an invaluable resource. Little of the empirical data presented here could have been gathered without his assistance.

In addition to my supervisors, two senior academics have played mentoring roles in the development of my thesis and associated work: Helen Keane from the Australian National University and Robin Room from the Centre for Alcohol Policy Research. Helen Keane spent several weeks in the Melbourne office of NDRI early in my candidacy, and I had the opportunity to discuss my work and the broader field with her. This began an ongoing conversation, and Helen's flair for frank and succinct advice and her personal warmth and enthusiasm have been invaluable. I look forward to remaining Helen's friend and colleague in years to come. I visited Robin's office on many occasions, and despite the pressures on his time, he always entertained my

queries and engaged with my concerns. He would often delve into his towers of paper to retrieve relevant artefacts, and his encyclopaedic knowledge of the alcohol literature was my access point to some of the historical texts on which the contemporary field has been built. It was a privilege to have access to a scholar of Robin's standing and calibre, and I am grateful to him for his generosity.

The intellectual contours of this work were significantly shaped by David Moore and Cameron Duff, my primary and secondary supervisors respectively.

During the period that I was preparing for candidacy, David kept a close watch on my progress and fielded almost daily enquiries about literature and theory. With the assistance of his keen eye for detail, his deep knowledge of the AOD field, and his particular expertise in ethnographic epistemology, I achieved a timely candidacy and was soon in the field. The meetings with David during my fieldwork were a vital source of reflection and advice and he helped me maintain a clear sense of the overarching direction of the project. In hindsight, I can see that my shifts in focus and approach along the way were well advised. During the stages of drafting and analysis, David provided many suggestions for the resources and techniques that enabled me to develop the work. At times, the standards David required of me seemed exasperating and, during one supervision, I complained that he was like a bouncer at the door of an exclusive club, and that he never liked my shoes. After further months of work, David began a supervision meeting with the statement, 'Welcome to the club'. Coming from David, this endorsement seemed momentous. In years to come I will consider the rigour David brings to expression, argument and critique to be my yardstick for quality, and I am grateful to him for that legacy.

Cameron Duff has brought a generosity, positivity and energy to his supervision that have been singularly enabling and motivating. Our many hours of conversation about the broader task of theorising AOD use in new ways has been deeply influential on my thinking and analysis, and will continue to shape the work I do in the future. Cameron's knowledge of theoretical literature introduced me to many of the resources I deploy in this thesis. His inclination to build a community of practice around his work provided me with an example of the affective and collegiate

dimension of a successful scholarly career. I am deeply grateful to Cameron for the roles he has played as a mentor and friend.

Dr Campbell Aitken of Express Editing Writing and Research provided professional editing services in accordance with the Institute of Professional Editors' *Guidelines for editing research theses*.

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I count my blessings in each of these attributions, and pledge to seize any available opportunity to perpetuate the practice of community, mentorship and support that is necessary to scholarly endeavour.

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## List of Abbreviations and Acronyms

AOD	alcohol and other drug
AIHW	Australian Institute of Health and Welfare
ARC	Australian Research Council
BAC	blood alcohol content
CISP	Court Integrated Services Program
CREDIT	Court Referral & Evaluation for Drug Intervention & Treatment
DHS	Department of Human Services [Victoria]
DSM/DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4 <sup>th</sup> Edition
GP	general practitioner
ICD	International Statistical Classification of Disease
NDRI	National Drug Research Institute
NHMRC	National Health and Medical Research Council
NSAODC	Northern Suburbs Alcohol and Other Drug Clinic
RSA	responsible service of alcohol
SES	socioeconomic status
SSRI	selective serotonin reuptake inhibitor
STS	science and technology studies
WHO	World Health Organization

# Chapter 1

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## Introduction

### **Alcohol problems**

Alcohol use, particularly young adults' heavy sessional drinking, has long been understood as a problem. The nature of the problem has been constituted in many different ways. In this thesis I approach the problem of young adults' heavy sessional drinking through the analytic techniques and ontological propositions of science and technology studies (STS). STS contends that problems such as young adults' heavy sessional drinking do not exist independently of the apparatuses used to define and measure them. That is not to say that there is no problem, rather it is to say that there are many problems, and that each one is shaped by professional disciplinary and scientific practices. In Chapter 3 I will introduce the propositions and implications of STS more fully, but for now, I will present some of the different disciplinary apparatuses at work in making young adults' heavy sessional drinking problems and the different planes of problems they enact: population problems, cultural group problems and individual problems.

At the population level, epidemiology has identified diseases in which alcohol is a causal 'factor', and estimated rates at which alcohol 'causes' death and disability (Rehm et al., 2010). Many of these effects cannot be determined within individual cases—as is the case with breast cancer, for example—but can be shown to exist at the population level. Breast cancer is more prevalent among women who drink heavily than among those who drink lightly or abstain (Ridolfo & Stevenson, 2001). For women drinkers, alcohol is labelled a 'component cause' of breast cancer. According to the International Statistical Classification of Disease tenth revision (ICD-10), alcohol is a 'component cause' of more than 200 diseases (Jürgen Rehm et al., 2009 p. 2223). Calculations about alcohol's role in these diseases, and others in which it is deemed to be a 'necessary cause', enabled a World Health Organization (WHO) study to attribute 3.8% of deaths and 4.6% of disability-adjusted life-years globally to alcohol (Rehm et al., 2009). In Australia, 3,271 deaths were attributed to

hazardous and harmful alcohol consumption during 1998 (Ridolfo & Stevenson, 2001 p. 118). A related approach emerging from sociology and criminology has estimated rates of violence and other crimes in which alcohol is a ‘factor’, and produced figures for alcohol’s harm to others. One study reported that 41 per cent of offences for which a sample of Australian offenders were detained were ‘attributable’ to alcohol (Payne & Gaffney, 2012 p. 3). Another study estimated that 70,000 Australians were victims of ‘alcohol-related’ assault in 2005 (Laslett et al., 2011 p. 171). Economics has been used to estimate various aggregated costs imposed by alcohol. For example, Collins and Lapsley (2008) estimated that, in Australia, alcohol-attributable healthcare costs totalled AUD\$1.9 billion in 2004/5 (p. 64), while a later study estimated that the ‘tangible’ cost of ‘alcohol’s harm to others’ in Australia during 2005 was AUD\$14.2 billion (Laslett et al., 2011 p. 178). In these ways, alcohol has been deemed to act upon and be a problem for populations.

Alcohol is also a problem, albeit a different one, for cultural groups. MacAndrew and Edgerton’s (1969) seminal study demonstrated that different cultural groups around the world behaved differently when intoxicated. Their insight was that ‘drunken comportment’ was mediated by culture and that drunkenness was, at least in part, a cultural practice. Drinking cultures and the injunctive norms governing drinking practices have long been of interest for sociological and anthropological researchers (Kapferer, 1988; Room, 1975), and they have been of increasing concern within policy documents produced in Victoria and Australia during the last decade (see analysis of these documents in Chapter 7). Drinking cultures have been identified at various scales, from whole nations (Ministerial Council on Drug Strategy, 2006 p. 26) to ethnic groups (A. J. Gordon, 1978; Moore, 1990) to microsocial worlds (Room & Callinan, 2014). Within this mode of study, the problems sometimes associated with heavy sessional alcohol use—violence, injury, public disorder and various forms of moral transgression—are understood to be related to group cultures. Some cultural groups sanction or prescribe heavy drinking, and some of these also sanction and prescribe practices that attract a response from state, civil and health authorities (Room, 1975). Particular concern has been expressed about the drinking cultures of ‘at-risk’ groups; for example, the state of Victoria has singled out the drinking cultures of ‘young people; rural and regional populations; people with a

mental illness; and Indigenous and CALD communities' (Victorian Government, 2008 p. 11).

Alcohol also acts upon individuals. Understandings of alcohol's effects upon individuals are commonly articulated from within disciplines of psychiatry, psychology, medicine, social work and related disciplines. These accounts mostly begin from the same premise: subjects only choose to drink heavily, which is necessarily risky, if they are not in full possession of the facts or if they suffer from some pathology. Subsequently, many of the responses to heavy sessional drinking that are addressed to individuals proceed from the basis that individuals who drink heavily require education or clinical treatment or both. Much effort has been deployed in public health education to address this problem, including the development of guidelines for safe drinking or tips for harm reduction, and various modes of clinical treatment to cure alcohol-related pathology. However, many of those who drink heavily and come to the attention of public health educators and clinicians are seemingly impervious to the information provided and unresponsive to the treatments. Guidelines for safe drinking have little traction with young adults (Harrison, Kelly, Lindsay, Advocat, & Hickey, 2011; Michael Livingston, 2012a), and, in 2010, 46% of Australian adults aged 20–29 years consumed alcohol at volumes that placed them 'at risk of injury' at least monthly or more frequently (Australian Institute of Health and Welfare, 2011b p. 57). According to the Alcohol and Other Drug Treatment Services National Minimum Dataset, across Victoria in 2009–10, alcohol was the most common 'principal drug of concern' for which treatment was sought, accounting for 46% of treatment episodes (Australian Institute of Health and Welfare, 2011a p. 100). Many of these cases represent repeated episodes of care, which are recognised as endemic to the alcohol and other drug (AOD) treatment system (Moore & Fraser, 2013).

### **Introducing the research questions and ethnographic field**

Contemporary developments in social science theory have suggested that each articulation of a problem, such as those above, constitutes it in a politically vested and methodologically mediated way (Bacchi, 2015; Law, 2004). Each articulation describes a particular plane of action and registers this action using particular

instrumentation. It brings a selection of the forces to which ‘the problem’ might be attributed to the fore and makes them present and accountable, while many other forces are necessarily obscured or absented. Understood in this way, social science is not so much in the business of accurately representing social problems, but of enacting them in partial, political, and incomplete ways (Latour, 2005). Some influential enactments of alcohol-related problems, such as those described above, shape policy and service delivery responses and the subjectivity of drinkers themselves. Some alcohol-related practices and entities are deemed to be in need of intervention, while others which might equally be implicated are left unattended. There are always choices to be made about how to constitute alcohol-related problems, and where the responsibility for them might be attributed. Following from these theoretical orientations, I address the following three research questions.

- How are heavy sessional drinking and its problems currently enacted in significant sites of research, policy and service provision?
- What are the effects of these enactments?
- How else might heavy sessional drinking and its problems be enacted?

These questions lead me into critical reviews of different bodies of alcohol research and associated policy and service provision. In response to the first two research questions, I consider enactments of young adults’ heavy sessional drinking problems across three influential disciplinary sites: epidemiological studies of alcohol-related morbidity and mortality; Victorian and Australian public policy concerned with ‘drinking cultures’; and clinical science informing practices within AOD treatment settings. In response to the third research question, each of these sites is juxtaposed with a counterpoint, an ethnographic site in which alcohol effects are co-produced by forces not otherwise accounted for. These counterpoising sites are each in Broadmeadows, a socioeconomically disadvantaged suburb in Melbourne’s north.<sup>1</sup>

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<sup>1</sup> The inclusion of ethnographic data from the City of Hume, in which Broadmeadows is located, was mandated by the epidemiological component of the ARC Discovery Project DP110101720, with which my PhD research was associated. Of the possible Hume sites, I selected Broadmeadows because of its geographic accessibility and because of its burden of socioeconomic disadvantage, a thematic concern in this thesis.

The counterpoising sites include young adult drinking events, a football club and an AOD treatment clinic. This material from the influential disciplines and counterpoising sites is presented in the form of a multi-sited ethnography in which young adults' heavy sessional drinking forms a common conceptual thread between various interrelated textual and spatial sites of various scales.

## **Introducing the chapters**

The chapters of this monograph follow the standard structure for a PhD thesis: introduction, literature review, methodology, results, and conclusion. This section outlines the role each of the following chapters plays.

In Chapter 2, I present a literature review of a selection of qualitative alcohol studies from Australia from the last two decades. I consider the methodologies and outline the theory, sampling approaches and data-gathering methods of the literature reviewed. I present the findings of the literature, considering themes of gender, risk and harm, risk and harm as functions of sex and gender, social class, maturation, and drinkers' experiences of confidence, transgression and control. I argue that, because of its theoretical commitment to social constructionism, the literature reviewed tends towards crafting statements that transcend or converge differences between modes of understanding heavy sessional drinking and its effects. I briefly detail the historical development of social constructionism and its effects upon the broader AOD field. I argue that converging differences between accounts of realities begs many questions about the nature of the 'real', and the significance of qualitative attempts to understand it.

In Chapter 3, I respond to the questions posed by the literature review and introduce some of the ontological, methodological and political propositions of STS, which contrast strongly with social constructionist approaches taken in the literature reviewed. I introduce some of the STS-informed AOD research to date, and argue for the significance of an STS-informed study of heavy sessional drinking among young adults.

In Chapter 4, I define the rationale for a multi-sited ethnography. I argue that a theoretical, non-conventional construction of an ethnographic field is well suited to revealing contrasts and similarities between different objects, particularly those that are conventionally understood to be the same thing, but are, in practice, worlds apart. With the justification of the methodological model in place, I introduce the sites constituting my ethnographic field. These site descriptions include rationales for including the site, descriptions of the site and my role within it, details of data-gathering methods, and an introduction to the techniques used in data analysis. I conclude the chapter with an account of the politics of my critical approach.

In Chapter 5, I begin presenting results from my study. I analyse the ways in which causality is constituted in one type of alcohol epidemiology—that concerned with morbidity and mortality. By analysing the causal propositions of a landmark text from the field, and following the reifications and re-articulations of its methods and findings, I detail processes of simplification required to enact order and make useful statements about alcohol and its effects. I consider the adequacy of these enactments in light of epidemiological literature documenting lower alcohol consumption and higher incidence of alcohol-related harms among low socioeconomic status (SES) populations.

The questions posed by the confounding relationship between SES and alcohol-related harms motivate the modes of analysis used in Chapter 6. This chapter is offered as a counterpoint to its predecessor. I examine some case studies of drinking events of young adults in Broadmeadows and consider what kinds of associations, between what kinds of actors, objects, entities, actants and forces were involved in the production of alcohol-related harms. I do so from the perspective that harms should be regarded as an effect of an assemblage of forces and their interrelations and not of any one discrete body therein. Framing the causes of harm in this way recognises the complex causality of alcohol-related harms and implicates the social, economic and material networks in which young drinkers are enmeshed.

In Chapter 7, I consider policy documents and academic literature addressing drinking cultures and, as a counterpoint, I offer a case study of drinking cultures and



efforts to alter them within an Australian Rules football club in Broadmeadows. Along the way, I develop an argument about the Good Sports Program, a government-funded policy initiative to change drinking culture in sporting clubs. I draw attention to the role of hegemonic masculinities within drinking cultures, and argue that a more specific engagement with masculinities, and the socio-material networks that hold them in place, can be helpful for cultural change policies to achieve reductions in the harmful effects of drinking events.

The final sections of this thesis that present results are Chapters 8 and 9. Both chapters contain analyses of ethnographic data collected at an AOD treatment clinic providing services to young adult heavy sessional drinkers in Broadmeadows, among other client groups. Chapter 8 details enactments of alcohol and other drugs and their use in the clinic, while Chapter 9 details enactments of clients and their life circumstances. In these chapters I demonstrate that the enactment of clients with a broad range of AOD use practices as ‘dependent’ foregrounds AOD use as the force to which life problems might be attributed, backgrounds other forces and depoliticises them, and stigmatises clients by rendering them pathological. Drugs enacted as dependence-forming are attributed with causal roles in adverse events and life circumstances, and their use is thus represented as dangerous and irresponsible. Drugs not enacted as dependence-forming are not attributed with problematic agency, and their role in generating life problems is left unattended. I demonstrate that tensions exist within all these enactments—that they might be done otherwise—and that de-emphasising the role of AOD use in shaping clients’ life circumstances affords a range of positive possibilities.

In the conclusion, Chapter 10, I reflect on influential enactments of young adults’ heavy sessional drinking and their effects. I contrast these with more situated enactments and argue that bringing the socio-material networks in which young drinkers are enmeshed to the fore helps to counter attributions of harm to the rational, self-entrepreneurial subject, and of the stable and quantifiable substances they consume. Finally, I argue that the harm reduction agenda and its research base should be expanded to include a wider array of political claims for people experiencing

socioeconomic disadvantage:<sup>2</sup> including adequate housing and suitable drinking settings; opportunities for employment; and protection from oppressive gender norms.

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<sup>2</sup> I use the concept of ‘socioeconomic disadvantage’ in this thesis rather than other typological devices for denoting sociological hierarchies of stratification such as ‘class’, ‘poverty’ and ‘exclusion’. I use ‘socioeconomic disadvantage’ because its methodological mechanics are more explicitly apparent than other notions, which can be amorphous. While various modes of enacting socioeconomic disadvantage exist (Pink, 2008; Vinson, Rawsthorne, Beavis, & Ericson, 2015), I take it to mean some metric of material, educational, financial, cultural and other related forms of wealth, capital or latent opportunity ranked in such a way as to indicate when individuals, geographic areas or other aggregates fall significantly below a midpoint established for a state or nation.

## Chapter 2

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# Literature review: From the specific to the general

In this chapter I review a selection of qualitative literature presenting data on young adults' heavy sessional drinking from Australia in the last 20 years. I detail the methodologies, theoretical orientations, sampling approaches and data-gathering methods employed within the literature reviewed. I describe its contributions to understandings of the meanings of heavy sessional drinking to its young adult practitioners, and discuss the findings concerning gender, interrelations between risk and harm and sex and gender, social class, maturation, and drinkers' experiences of confidence, transgression and control. These findings are situated within the broader tradition of social constructionist AOD research. Within this theoretical approach, the operative entity structuring the behaviour of the substance user is less the substance itself or the inherent traits of the user, and more the ideas that a user has socially acquired about the substance. I argue that, because of its theoretical commitment to social constructionism, the literature reviewed tends towards crafting statements that transcend or converge different modes of understanding heavy sessional drinking and its effects. I elaborate this point by considering the literature's attempted conflation of the emic and etic with regard to female drunkenness, class-specific drinking practices and risk and harm in drinking events. In these thematic areas, generalisable findings are crafted by a dialectic tacking between local symbolic orders and macrosociological propositions. I conclude that in the course of making a single sense of the specific and the general, the literature begs many questions about the nature of the 'real', and the significance of qualitative attempts to understand it. These questions include: in what way are risks and harms real if they're understood differently in different symbolic orders? Is the job of qualitative research to achieve the convergence of different symbolic orders? What role has public health science played in making the risks and harms of heavy sessional drinking 'real'? These questions are addressed in Chapter 3.

Fifteen publications are included in this literature review. I identified most of the publications by searching the 'Drug' database in the *Informit* search engine, using the terms 'Australia', 'qualitative' and 'alcohol'. Other publications were identified by searching through the citations and references of some of the literature reviewed. A major Australian literature review entitled *Young people and alcohol: The role of cultural influences* (Roche et al. 2008) was comprehensively searched for references to relevant literature. Each publication included in the review:

- is sociological in nature,
- presents a significant component of qualitative data,
- is Australian,<sup>3</sup>
- is contemporary (the oldest included study is from 1999), and
- includes (but is not necessarily limited to) young adults' heavy sessional drinking.

These criteria were chosen because of their congruence with the research concerns and methodology of this thesis. Table 1 presents a complete list of the literature included, along with columns indicating which studies fit with the thematic and methodological characteristics I identify.

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<sup>3</sup> A publication from New Zealand (Lyons & Willott, 2008) is included because of its similar cultural context and particular relevance to the concerns of my study.

**Table 1—Themes in recent Australasian qualitative alcohol literature**

Themes in recent Australasian qualitative alcohol literature	sampling strategies			emic themes				
	specific settings	ethno. studies of social networks	non- naturalistic studies	confidence	Peer group affiliation	transgression	control	maturation
Abbott-Chapman, Denholm, & Wyld, 2008			x	x		x		x
Borlagdan, Freeman, Duvnjak, Lunnay, Bywood, & Roche, 2010	x		x		x	x	x	
de Crespigny, Vincent, & Ask, 1999								x
Grace, Moore, & Northcote, 2009	x				x			
Jones, & Reis, 2012			x					x
Lindsay, 2006	x		x					x
Lindsay, 2012			x					
Lunnay, Ward, & Borlagdan, 2011				x	x	x		
Lyons, & Willott, 2008		x	x	x	x		x	
Moore, 2010		x	x	x				
Nairn, Higgins, Thompson, Anderson, & Fu, 2006	x		x					x
Northcote, 2006	x		x	x	x			x
Northcote, 2011	x		x					
Sheehan, & Ridge, 2001			x		x	x		
Thompson, Palmer, & Raven, 2011	x		x		x			

**Themes in recent  
Australasian qualitative  
alcohol literature**

	etic themes			risk & harm				
	changing gender roles	class / SES	neo- liberalsim, globalisation	cites quant. lit.	behaviours	minimisat- ion	gender	defintions
Abbott-Chapman, Denholm, & Wyld, 2008	x		x		x		x	x
Borlagdan, Freeman, Duvnjak, Lunnay, Bywood, & Roche, 2010		x	x	x	x		x	x
de Crespigny, Vincent, & Ask, 1999				x		x	x	
Grace, Moore, & Northcote, 2009				x	x	x	x	x
Jones, & Reis, 2012								
Lindsay, 2006	x	x		x	x	x		
Lindsay, 2012		x			x	x	x	
Lunnay, Ward, & Borlagdan, 2011								
Lyons, & Willott, 2008	x			x			x	
Moore, 2010					x			x
Nairn, Higgins, Thompson, Anderson, & Fu, 2006				x				
Northcote, 2006		x						
Northcote, 2011								
Sheehan, & Ridge, 2001	x	x		x	x		x	x
Thompson, Palmer, & Raven, 2011								

## **Constructing emic accounts**

In this section I demonstrate that the literature reviewed focuses on the meanings ascribed to heavy sessional drinking practices by the young adults engaged in them. I will make this argument with reference to three broad sampling approaches identified in the literature: studies centred on specific settings, ethnographic studies of particular social networks, and non-naturalistic studies. Some studies used more than one of these techniques. In the studies of particular settings, researchers gathered data by observing what they encountered in their place of interest. An eclectic range of contexts were studied: licensed venues in Melbourne (Lindsay, 2006); high school formals in New Zealand (Nairn, Higgins, Thompson, Anderson, & Fu, 2006); nightclubs in Perth (Northcote, 2006); youth and music festivals, national celebrations, and sporting events in Victoria and South Australia (Borlagdan et al., 2010), and football games and post-match pubs in suburban Adelaide (Thompson, Palmer, & Raven, 2011).

A few studies used ethnographic field observations to follow social networks of young adults over extended periods. Three studies described by Moore (2010) took place in Perth (2) and Melbourne (1) and gathered data over 12 to 18 months. Fieldwork was conducted in restaurants pubs, clubs, outdoor music events and private parties.

Studies of settings and social networks tended to supplement observational data with interviews or focus groups of individuals from the target group. Lindsay (2006) recruited a convenience sample of individuals (n=35) from Melbourne venues into interviews at a university campus (Lindsay, 2006), while Nairn et al. (2006) interviewed 29 individuals in group sessions at high schools, prior to and a few weeks after their 'formal' events. These participants volunteered to participate, after a general invitation was issued to all those attending. Each of the three ethnographic studies described by Moore (2010) conducted around 30 in-depth interviews with social network participants. Borlagdan et al.'s (2010) field observations (n=12) informed the design of subsequent stakeholder interviews (n=50), focus groups (n=20) and individual interviews (n=50), while Thompson et al. (2011) complemented ethnographic fieldwork with 93 structured, open-ended interviews

with male and female football fans. Borlagdan et al.'s (2010) focus group and interview participants were recruited from a stratified, purposive sample, incorporating participants stratified according to different geographical, schooling, life transition stage, demographic and 'risk factor' criteria. Thompson et al. (2011) interviewed a convenience sample of football supporters from four clubs.

Some studies exclusively gathered data through the non-naturalistic techniques of focus groups, interviews and questionnaires. Abbott-Chapman, Denholm & Wyld (2008) conducted eight single-sex focus groups of 'mainstream' Year 11 & 12 students in Tasmania in preparation for a later survey of 954 students and 2200 parents in four representative senior secondary schools and colleges. In this study, parents and students were asked similar survey questions, and the researchers compared the risk-taking practices of different generations. Lyons and Willott (2008) facilitated eight focus groups among workplace-based, mixed gender groups of friends (n=35) aged 20–30 years in Auckland. Sheehan and Ridge (2001) recruited focus groups of Year 9 and 10 women from four different schools in Victoria, located in country, metro eastern, lower income and fringe areas. Jones and Reis (2012) used focus groups in preparation for a questionnaire-based study of 1263 12–17-year-olds. Lindsay (2012) interviewed 20–24-year-olds in Melbourne, Geelong and Warnambool.

With one exception (Abbott-Chapman et al., 2008), sampling strategies in the literature reviewed focus upon young drinkers themselves and groups of peers in drinking settings, institutions (e.g. schools and workplaces) or social networks. The effect is to focus on the meanings of drinking practices as constructed by the young adult drinkers themselves. In the one exceptional case, only quantitative data were gathered from parents, and the survey questions asked had been piloted with younger drinkers, so the nuanced meanings of drinking practices to the older generation were not brought into focus. With these observations in mind, I can state that the literature reviewed focuses on the meanings ascribed to heavy sessional drinking practices by the young adults engaged in them.



Confidence, transgression, (losing) control, peer group affiliation and maturation were recurrent emic themes developed in the literature (Borlagdan et al., 2010; Lyons & Willott, 2008; Moore, 2010; Sheehan & Ridge, 2001). According to Lunnay, Ward and Borlagdan (2011), confidence ‘arises from the feeling of acceptance and belonging achieved through emulating social competencies in drinking behaviours’ (p. 433). This observation places the emphasis on the symbolic cachet of alcohol more than its pharmacology in enabling this experience.

Transgression is one of the social competencies gained by young drinkers (Sheehan & Ridge, 2001). Young drinkers can experiment with transgressive identities with the assurance that alcohol will go some way towards distancing them from any risk to their stable identity (Borlagdan et al., 2010). In this sense, alcohol can be ‘a facilitator of more fluid movement between established “masks” that are externally defined and alternate “masks” over which young people feel they have more sovereignty’ (Borlagdan et al., 2010 p.75). The tension between control and loss of control, and the strategies used to negotiate it also feature in qualitative literature. Alcohol consumption is used for the performance of particular identities, and in that respect it grants drinkers another dimension of symbolic competency and increased control over their projections of self to others. At the same time, alcohol use comes at the risk of loss of control through inebriation, and may demonstrate symbolic incompetence through the unreflexive performance of dominant stereotypes of alcohol-induced behaviour. This, argued Borlagdan et al. (2010), is a contradiction at the heart of drunkenness. These arguments have developed in light of earlier work from the UK. For example, Measham (2004) wrote about the dilemma: ‘the user not only pursues a desired state of intoxication but attempts to avoid an undesired state’ (p. 319). There is a ‘lack of cultural credibility to extreme intoxication’ and a ‘rational cost-benefit analysis in recreational drug use’ (p. 319). Some of the participants sampled within the literature commented on their negotiations of this narrow edge. For example, among the 14–24-year-olds in Borlagdan et al.’s (2010) study, the ideal state of drunkenness was ‘at the utmost limit of where a good time turns into a bad one’ (p. 121).

Peer group affiliation was identified as a powerful driver of drinking practices in the studies reviewed. ‘Belongingness is highly valued by young people’, wrote Bolagdan

et al. (2010), and ‘it makes young people’s decisions around alcohol inseparable from negotiating belongingness’ (p. 33). Drinking was a demonstration of ‘commitment to the party’ (p. 35) that afforded inclusion, while not drinking could result in being labelled a ‘spy’ (p. 37). Grace, Moore and Northcote (2009) also found that alcohol played a ‘pivotal role in socialising’ (p. 23) and was ‘significant in affirming the bonds between members of their core group’ (p. 24). Lunnay et al. (2011) theorised that drinkers who performed collectively legitimated drinking practices in a peer group achieved a kind of strategic investment in their accumulation of ‘symbolic capital’ (p. 434). Thompson et al. (2011) found that a drinking group they studied formed a ‘social capital’ resource for its members (p. 397). For participants in Sheehan and Ridge’s (2001) study, narratives of drinking events were important in group identification and bonding, some of which ‘had been told and retold within the group many times’ (p. 358). Northcote (2006) argued that clubbing and drinking together served to ‘reaffirm the peer group’ (p. 10).

The final emic theme in the literature I need to mention is maturation. Several studies mention the role of drinking events in young people’s rites of passage, and the ways that ‘age and stage’ influence drinking habits. Northcote (2006) studied the role of nightclubs as liminal spaces where rites of passage between childhood and adulthood are performed and identities are constructed, finding that nightclub attendance was much less likely after age 25 (de Crespigny, Vincent & Ask, 1999; Northcote, 2006). For teenagers, becoming drunk when consuming alcohol is what you ‘normally do’ (Nairn et al., 2006 p. 288) or what ‘it was all about’ (de Crespigny et al., 1999 p. 447). In Borlagdan et al.’s (2010) study of drinking among 14–24-year-olds, the desired state of intoxication could be described as somewhere between ‘drunk’ and ‘paro’ (paralytic) or ‘hammered’, and was mostly manifest in the context of the group relations rather than physical symptoms. In contrast, for drinkers over 23 years of age in de Crespigny et al.’s (1999) study, a particular level of intoxication (often described as ‘tipsy’ among females) could generally be identified, reached and maintained, avoiding the potentially embarrassing and physically unpleasant symptoms of going beyond this. Developing this theme about associations between levels of drunkenness and young adult maturation, in their research with a panel of Danish 18–19-year-olds, Demant and Järvinen (2011) documented a collectively

generated norm of ‘controlled drunkenness’. Whereas the same focus groups boasted of drinking ‘over the limit’ when they were aged 15–16, they were less tolerant of ‘people who can’t control themselves’ at age 18–19 (p. 95). The study found that the quantities of alcohol consumed were not much different, but the norms governing drunken behaviour had changed. The authors argued that drinking in ‘the right way’ tended to enhance the social standing of young adult drinkers, while drinking in ‘the wrong way’ (pp. 99–100) required the group to make a choice: accommodate its norms to the transgressors’ behaviour, reform the transgressor in the direction prescribed by the majority, or reject the transgressor. Demant and Järvinen’s theme of norms and sanctions changing with the maturation of a group of drinkers is consistent with the findings in the Australian literature I review.

The themes of confidence, transgression, (losing) control and maturation have been brought into focus because the sampling and data gathering methods employed in the studies reviewed explicitly set out to develop emic accounts of heavy sessional drinking. The aim of the sampling and data-gathering methods was to develop insights into the meanings of drinking practices among young adult drinkers themselves. We might observe that, in taking this approach, the research took the structure of symbolic meaning and cultural representation as its primary concern. Certainly, this observation is borne out by those studies including an explicit account of their theoretical approach. Of those studies that made the theoretical dimensions of their work explicit, the work of Bourdieu was most commonly drawn upon. Lindsay’s (2006) work on the ‘class locations’ of Melbourne venues drew from Bourdieu’s work on distinction and taste. Lunnay et al. (2011) employed Bourdieu’s theories of social capital and field. Their analysis centred on forms of ‘symbolic struggle’ within the field, as participants manoeuvred for recognition, distinction and inclusion within the social network. Bourdieu’s theories were employed as a ‘methodological toolbox’, and included a technique in which ‘the conditions of the research interactions was relinquished as much as possible’ into the hands of participants (p. 435), to ensure their ability to influence the terms of representation. Lyons and Willott (2008) used Foucauldian discourse analysis, and a ‘communities of practice’ construct drawn from critical psychology, a theoretical device much like Bourdieu’s ‘field’. Northcote (2011) employed theories of planned behaviour to

explain decision-making around ‘binge’ drinking. These approaches, and the findings they generated, are all oriented towards symbolic ordering and modes of representation. The history and implications of this orientation is the topic of the next section.

## **Social constructionism**

The theoretical and methodological underpinnings of sociology in the early 20<sup>th</sup> century included phenomenology, ethnomethodology, existentialism and symbolic interactionism (Denzin, 1992). The latter category became the most influential in the AOD field, particularly through the influence of George Herbert Mead (cf. the works collected in Reck, 1964). Mead was a canonical author for the ‘Chicago School’ of sociology (Denzin, 1992), which undertook the first self-consciously scientific qualitative AOD studies from the 1920s (Rhodes & Moore, 2001). Lindesmith, a Chicago scholar, published an influential symbolic interactionist study of opiate addiction in America in 1938. The study established a sociological theory of addiction that stood in contrast to the trait theory in ascendency at the time, in which the addict used drugs to ‘compensate for, or avoid their inferiorities and mental conflicts’ (Lindesmith, 1938 p.594). Rather than attributing addiction to some deviance or deficiency in the addict’s character, Lindesmith argued that addiction arose from the user’s explicit recognition that unpleasant physiological symptoms resulted from the absence of the drug—from withdrawal—and that re-administering the drug alleviated the symptoms. According to Lindesmith, the link between physiological symptoms and absence of the drug would not usually arise independently within the mind of the addict, but would be introduced via culturally mediated knowledge of opiate use and its effects.

A later study of marijuana use by Becker (1953), whose debt to Lindesmith is acknowledged, similarly rejected theories identifying ‘those individual psychological traits which differentiate marihuana users from non-users and which are assumed to account for the use of the drug’ (p. 235). Instead, what Becker found common to all marijuana users was a learned set of skills for consuming the drug to achieve physiological effects, and a set of culturally mediated attitudes towards those effects which render them pleasurable:

marihuana-produced sensations are not automatically or necessarily pleasurable. The taste for such experience is a socially acquired one, not different in kind from acquired tastes for oysters. (1953 p. 239)

This statement draws attention to the moralised and therefore problematic nature of reductionist trait theories, for few would argue that an acquired taste for oysters is evidence of deviant or psychopathological traits. Instead, Becker, like Lindesmith, identified the social acquisition of a cognitive disposition as the causal mechanism. Becker and Lindesmith's theories of drug use could be extended towards a more general theory of behaviour. Becker expressed it thus:

if a stable form of new behavior toward the object is to emerge, a transformation of meanings must occur, in which the person develops a new conception of the nature of the object. (Becker, 1953 p.242)

Within this theory of behaviour, the operative entity structuring the behaviour of the substance user is less the substance itself and more the ideas that a user has about the substance. This is to say that the substance user's definition of the situation was *the* situation as far as the Chicago School of AOD researchers were concerned. While symbolic interactionists argued for an 'interpretive, subjective study of human experience', they also 'sought to build an objective science of human conduct, a science which would conform to criteria borrowed from the natural sciences' (Denzin, 1992 p. 3). To unite these seemingly incommensurable ontological and epistemological tenets, symbolic interactionists positioned the substance-using subject as the final authority and ontological fulcrum for sociological questions concerning AOD use.

Symbolic interactionism was to remain the primary theoretical orientation of qualitative AOD research until the 1980s (Rhodes & Moore, 2001), although the discipline evolved along with ongoing changes within sociology more broadly (Denzin, 1992). Little contemporary research is identified as symbolic interactionist, but instead the historical symbolic interactionist literature can be drawn together with the contemporary qualitative alcohol literature—including that deploying the theories

of Bourdieu—under the banner of ‘social constructionism’. Insofar as it is a meaningful concept, social constructionism is a ‘convenient shortcut’; ‘less a specific body of work and more a general ontological and epistemological stance, a certain way of delimiting and apprehending the social’ (B. Anderson & Harrison, 2010 p. 4). According to Jarvie, within social constructionism, ‘all assessments are assessments relative to some standard or other, and standards derive from cultures’ (Jarvie, 1983 p. 46). ‘The social’ within social constructionism is understood as a ‘culture’, a shared suite of representational meanings; a ‘symbolic order’ (B. Anderson & Harrison, 2010). Insofar as representational meanings are shared between individual subjects apprehending them, representations constitute the social. Symbolic orders do not exist only at the scale of the emic microsocial worlds studied in the qualitative alcohol literature; social constructionists also consider the symbolic orders operating at larger scales. In social constructionist studies, it is typical practice to widen the analytical frame to consider some of the macrosociological forces at work within the microsocial worlds studied. This is necessary to establish the significance of the research beyond the micro-worlds studied and to achieve more generalisable findings. In order to calibrate these macrosociological statements, social constructionist researchers seek to craft statements that accommodate local emic realities, yet exceed each of them.

For example, MacAndrew and Edgerton (1969) documented a wide range of different understandings of alcohol in an intercultural study. They argued that the link between ‘bad’ behaviour and alcohol intoxication had been socially constructed in some societies, but not others, disrupting the deterministic links postulated by more positivist alcohol science (Room, 2001). Room (1975) contributed another historically significant social constructionist argument based on a macrosociological analysis, arguing that many of the ‘social problems’ associated with alcohol consumption are best understood as arising from conflicts between adjacent but differentiated ‘behavioural norms’ (that is, symbolic orders) governing alcohol use and intoxication. With this argument, Room set out to challenge the prevailing view that individual transgression or the pharmacological effects of alcohol caused the ‘social problems’ associated with alcohol use. In Room’s analysis, the effects of competition between various symbolic orderings of intoxication and understandings

of alcohol use were the source of social problems associated with heavy sessional drinking.

By comparing and contrasting multiple and various emic accounts, these studies exceed the microsocial perspective and develop abstracted and expert, or etic accounts. Many of the qualitative studies of young adults' heavy sessional drinking in Australia also developed etic accounts of their phenomena of concern. These accounts and some of their effects are considered in the next section.

### **The etic point of view**

This section details the reviewed literature's account of some of the macrosociological forces shaping heavy sessional drinking, and considers the techniques used to animate the qualitative data on a wider scale.

Several authors considered the effects of changing gender roles (Abbott-Chapman et al., 2008; Killingsworth, 2006; Lindsay, 2006; Lyons & Willott, 2008; Sheehan & Ridge, 2001). Most noted that heavy sessional drinking is becoming a less exclusively male practice. This change has been associated with delayed child-bearing, financial independence for women, marketing strategies and the increasing prominence of women in public roles and spaces (Lindsay, 2006; Lyons & Willott, 2008). Women's heavy drinking is said to be symbolic shorthand for equality and independence (Killingsworth, 2006; Lindsay, 2006). More specifically, women's heavy drinking is an appropriation of hegemonic behaviour which is complicit with rather than subordinate to masculinity (Lyons & Willott, 2008). These observations can be contextualised within a broader body of literature. Historically, public bar drinking among the Australian working class has been represented as almost exclusively masculine (Barbara, Usher & Barnes, 1978), although the accuracy of these representations has been challenged (Kirkby, 2003). The cultural role of alcohol advertising featuring macho 'ocker chic' has been investigated in detail by Kirkby (2003) and it has been argued that alcohol consumption has played a central role in the construction, performance, reproduction and defence of 'hegemonic masculinities' (Campbell, 2000 p. 564). This link was partly a result of advertising,

which still draws heavily on the beer/‘hard man’ association (Lyons & Willott, 2008).

It is clear that changing gender roles were a macrosociological interest framing some of the qualitative studies. The effects of this macrosociological force were tested with reference to empirical data gathered from the emic realm. Gender disparities remained a significant theme within the literature. Enactments of gender feature in drink choices: spirits and wine are more popular feminine drinks (Lindsay, 2006) and when selecting alcopops, common among younger drinkers, females favour fruit flavours mixed with vodka and males prefer cola-based bourbon mixers (Jones & Reis, 2012). Beer is particularly favoured by men (Grace et al., 2009; Lindsay, 2006). In Lyons and Willott’s (2008) study, even men who did not like beer chose it because that’s ‘what you do’ as a man (p. 701).

Sheehan and Ridge (2001) found that young women’s drinking is viewed as more transgressive than for their male counterparts, and male participants in Lyons and Willott’s (2008) study derided drunk women who were older or attractive, while female participants associated public drunkenness among women with sexual waywardness. The same (male and female) participants saw male drunkenness and sexual availability as respectable. One study detailed the ‘grog squad’, a group of about 20 male football supporters who engaged in the consumption of enormous quantities of alcohol and indulged ‘sexist, misogynist, homophobic discourses and practices’ (Thompson et al., 2011 p. 397). While the etic accounts of drinking and gender enthused about female emancipation through alcohol consumption, emic accounts derided female heavy drinking as wayward and transgressive, and in doing so reinforced the role of alcohol in demarcating masculine hegemony.

In one study, positive and empowered representations of female drunkenness were understood as partly associated with culturally capitalised drinking settings, while female drunkenness in more prosaic or ‘mainstream’ drinking settings remained stigmatising. Lindsay (2006) suggested that, in general, masculinity and femininity were more accentuated within working-class ‘commercial’ venues than their ‘niche’ middle-class or subcultural counterparts. Sexualised dancing and overt sexual



approaches were common between men and women in commercial venues, but heterosexual activity in niche venues was more subtle. Lindsay (2006) observed that the women in middle class or subcultural venues drank almost as much as men and had similar behaviours, while women in predominantly working-class venues emphasised their femininity and drank much less than their male counterparts. The ratio of men to women patrons across all 10 Melbourne venues studied was about 60:40.

Overall, the qualitative literature points out that the public heavy sessional drinking of young adults is no longer as exclusively masculine as it was, but that it is still a heavily gendered practice. These researchers performed a dialectic tacking between a macrosociological force and emic accounts of microsocial worlds. Scales of symbolic order were calibrated against one another to synthesise the findings.

Class, or socioeconomic stratification, is also an etic theme in the literature. Unlike the changing gender roles theme, socioeconomic stratification does not feature much in the qualitative data and appears as more of a professional than a lay concern. Etic understandings of intersections between class and drinking have been advanced in literature from the UK, where ‘the excessive, irresponsible, anxiety-provoking figure of the “binge drinker” is generally marked as young, white and working class’ (Griffin, Bengry-Howell, Hackley, Mistral, & Szmigin, 2009). Griffin et al. argued that white, working-class heterosexual masculinity was once tied to production and has since been displaced to the arena of consumption (Griffin et al., 2009 pp. 461–462). Reflecting these themes in the Australian context, Lindsay (2006) reflected that the shift of class identities away from production and towards consumption practices made drinkers’ pursuit of pleasure on a night out an expression of their working-class, middle-class or subcultural social capital. These arguments were buttressed in her article by quotations from interview participants suggesting that some venues were ‘over-priced’, ‘corporate’, and ‘pretentious’, which we might read as ‘middle-class’; while others were ‘processed’, ‘cheesy’ and ‘gross’, which we might read as ‘working-class’. We can see from these quotations that the young adult drinkers themselves were not as explicit about class distinctions, or used rather more circumspect language in their descriptions of them. Other reviewed studies also

addressed connections between socioeconomic stratification and drinking, but did not present any corresponding qualitative data. Borlagdan et al. (2010) found that the practices and functions of alcohol use among homeless young people was markedly different from their suitably housed peers, and recommended further research. Lindsay (2012) also found some connections between heavy drinking, violence, and young men ‘wanting to make a name for themselves’ (p. 3), but the incidence of violence in metropolitan, post-industrial and rural cities were not strongly class-specific, and university students were as likely to have experienced alcohol-related violence as non-professional workers. Descriptions of pride in being tough or winning fights were notably absent from the testimony of participants from all classes and genders (Lindsay, 2012). Again, explicit references to class structures were not evident in the qualitative data but were induced in the researchers’ arguments. Northcote (2006) argued that ‘the standardisation of fashionable or cult dress’ in nightclubs served to obscure class differences among their patrons (p. 8), and described his sample as coming from ‘white, middle-class backgrounds’ (p. 2). Sheehan and Ridge (2001) stratified their sampling by relative socioeconomic advantage. Neither study presented data concerning the class stratifications their participants employed. In each of these studies, notions of class roles and distinctions employed etic conceptions of macrosociological forces, and the researchers imposed these categorically upon their sample rather than developing them inductively.

Other macrosociological etic conceptions of drinking practices include the enactment of neoliberal subjectivities (Borlagdan et al., 2010), and an increase in the impulsive and hedonistic behaviour attributed to globalisation, increasing competitiveness and social exposure in public spaces (Abbott-Chapman et al., 2008). These etic concerns are not derived inductively from the data.

Drawing these observations back to the broader critique of social constructionism, social constructionist AOD research seeks to represent macrosociological phenomena by making statements that hold true across multiple microsocial symbolic orders. Sometimes this is achieved through analyses of data and dialectics between the macro and micro scales; sometimes it is imposed upon the analysis through prefigured sociological theory. However, if one follows the deeper

implications of the social constructionist proposition that ‘all assessments are assessments relative to some standard or other, and standards derive from cultures’ (Jarvie, 1983 p. 46), then fissures begin to emerge within this relationship between the emic and the etic. Firstly, etic concerns are no less a result of fabrication and social construction than their emic counterparts. Secondly, there are clear power differences between the emic and the etic, but social constructionism is not well equipped to identify these, or the effects they have. In the next section, I will consider this problem in relation to the discussions of the risks and harms associated with heavy sessional drinking in the literature reviewed.

### **Risks, harms and ontological questions**

In establishing the significance of their empirical concern, much of the qualitative literature cites figures developed by quantitative public health research about alcohol use (e.g. Borlagdan et al., 2010; de Crespigny et al., 1999; Grace et al., 2009; Lindsay, 2006; Lyons & Willott, 2008; Nairn et al., 2006; Sheehan & Ridge, 2001). Publications from the National Drug Strategy Committee, National Health and Medical Research Council (NHMRC), and the National Survey of Mental Health and Wellbeing are commonly cited in these sections. Some statements of concern are made with reference to quantitative findings: alcohol use cost approximately \$15.3 billion in 2004–05 (Collins & Lapsley, 2008; cited in Grace et al., 2009); consumption of greater quantities of alcohol in a single sitting has ‘consequences’ such as unprotected sex (Alcohol Concern, 2000; cited in Lyons & Willott, 2008); approximately 18% of 18–24-year-olds drink at levels that place them at risk or at high risk of road injury and violent assault on a fortnightly basis (Chikritzhs et al., 2003; Clement, 2007 cited in Grace et al., 2009). Each of these public health statements positions alcohol as a mostly malign agent, responsible for a range of health problems in the population. However, in the qualitative literature reviewed, the public health statements are often accompanied by assertions about the importance of going ‘beyond broad quantitative outlines’ (Lindsay, 2006 p. 30) by using qualitative data, thereby facilitating a more nuanced approach to harm reduction measures.

Violence, risky behaviours and efforts by drinkers to minimise risks are themes in some of the qualitative findings. One study (Grace et al., 2009) identified various risky behaviours at drinking events: drink-driving, becoming embroiled in fights or arguments, putting themselves at risk of physical injury (e.g. falling asleep in a public place and being assaulted) and arguments with partners. Grace et al. (2009) also noted harm avoidance strategies: planning transportation; avoiding specific venues; sticking together; avoiding or diffusing arguments and fights; consuming food and water; taking care with other drugs; and chastising friends for drink-driving. Hickey et al. (2009) noted that young people's drinking (including young adults and the under-aged) was sometimes allowed in community sporting clubs, as some parents regarded them as lower-risk contexts than unsupervised environments elsewhere.

Other discussions of risk and harm were generally presented as gender enactments. In two studies, women were less likely to take risks and were less in danger of physical harm than men (de Crespigny et al., 1999; Grace et al., 2009). Abbott-Chapman, Denholm and Wyld (2008) speculated that this was because as children and adolescents, females choose more indoor leisure activities than males and this meant they were subject to more adult surveillance. While contemporary female adolescents took fewer risks than their male counterparts, they took more risks than their mothers did at a similar age (Abbott-Chapman et al., 2008). Lindsay's (2012) study, which was the only one reviewed taking the link between alcohol and violence as its primary concern, found that 'the male gender of both the perpetrators and potential victims of public violence is taken for granted' (p. 6). Common reported precipitants of fights between young male drinkers included jealousy over women, rivalry between football teams, allegations of cheating during games of pool, squabbles over bumping and spilt drinks, and aggressive bouncers (Grace et al., 2009; Tomsen, 1997). In de Crespigny, Vincent and Ask's (1999) study, male harassment and violence was a significant issue for women drinkers. Where sexual assault was concerned, several studies identified a complex discourse around men attacking drunken women. Young women reported that they actively used alcohol to pursue sexual encounters (Sheehan & Ridge, 2001), and some described being 'taken advantage of' whilst intoxicated (Borlagdan et al., 2010 p. 139). Young women

actively guarded themselves and each other from sexual predation through multiple strategies (de Crespigny et al., 1999; Sheehan & Ridge, 2001), but when sexual assault occurred, men were understood to be taking advantage of the situation according to pre-ordained gender and power roles, leaving them ‘invisible and exonerated from any wrong doing’ (Borlagdan et al., 2010 p. 4). Borlagdan et al.’s (2010) study participants attributed responsibility for drunken sexual assaults firstly to the alcohol itself, and secondly to the young women. Two authors noted female-specific harm avoidance strategies, with young women sticking together throughout events and avoiding venues hosting aggressive men (de Crespigny et al., 1999; Lindsay, 2006). Young women reported that their vulnerability to attack was often used to justify their differential treatment and the social exclusion of women from social drinking events (Lyons & Willott, 2008; Sheehan & Ridge, 2001).

The emic practices for defining and operationalising notions of risks and harms were explored in some of these studies. The low income group of participants (all female) in Sheehan and Ridge’s (2001) study reported the highest level of exposure to alcohol-related harms, but also reported the highest rate of positive drinking experiences. Sheehan and Ridge (2001) found that the (researcher-defined) distinctions between positive and negative drinking experiences were not clear for their participants, as drinking events were perceived holistically. Borlagdan et al. (2010) noted that, among the common physiological reactions to intoxication (e.g. vomiting, tiredness and headaches), there is nothing inherent that ‘determines how such reactions are perceived by young people’ (p. 122). Instead, some instances of harm were understood by some young people as earning ‘bragging’ rights (p. 123), and ‘going too far’ (p. 122) was associated with withdrawing, or being forced to withdraw, from the social group. ‘What is really at risk then is young people’s social recognition and esteem’, concluded Borlagdan et al. (2010 p. 120). In this statement are echoes of research from the UK arguing that conceptions of the risks and harms of drug use are contingent upon class and worldview (Nutt, 2009). Participants in Abbott-Chapman et al.’s (2008) study did not avoid risk but experimented in order to find their limits and develop social competence. Their risk-taking was associated with self-confidence and a majority of their (female) participants reported that ‘to live successfully, there are some risks you have to take’ (p. 140). Borlagdan et al.

(2010) found that risk-taking is necessary ‘proof of commitment’ to a group and was an important facilitator of social unity at youthful drinking events (p. 39).

Although some of the qualitative literature avoids constructing heavy sessional drinking as inherently problematic, some authors aim to inform harm reduction measures (Abbott-Chapman et al., 2008; Grace et al., 2009; Sheehan & Ridge, 2001) and some of the literature reviewed has set out to contribute to debates surrounding the harm reduction agenda. For example, Borlagdan et al. (2010) argued that ideas about drinking are usually expressed as dichotomies, but these should be revised to be more reflective of continuums, stating that ‘From a public health perspective, it is important to challenge this dichotomy and highlight the potential for a middle ground between not drinking and drinking to intoxication’ (p. 47). Arguing a contrary point, Abbot-Chapman et al. (2008) argued for a clearer differentiation between ‘good’ and ‘bad’ risks. Some authors argued for future interventions to take a youth-centric perspective and acknowledge pleasure and other benefits of drinking, while also acknowledging a desire to reduce harm (Abbott-Chapman et al., 2008; Grace et al., 2009; Sheehan & Ridge, 2001).

These statements can be interpreted as seeking to achieve a convergence between the quantitative understandings of risks and harm in the public health literature and the qualitative understandings of risk and harm identified in the microsocial worlds studied. This drive towards convergence is a common trope in qualitative health research. For example, it is evident in qualitative literature on steroid use among bodybuilders (Grogan, Shepherd, Evans, Wright, & Hunter, 2006) and on recovery from anorexia nervosa (Federici & Kaplan, 2008). It is this tendency towards convergence within social constructionism—convergence between the emic and the etic, and between the macrosociological and the microsocial—and its ontological implications, that I wish to critique.

The public health definitions of risk and harm and the definitions operative within the microsocial worlds studied are both presented as ‘real’, but real in different ways. In the discussion of social constructionism, I showed that the substance user’s definition of the situation was *the* situation as far as the symbolic interactionists were

concerned, and this position is echoed within some of the literature reviewed. One example is Borlagdan et al.'s statement that 'What is really at risk then is young people's social recognition and esteem' (2010 p. 120). On the other hand, in some of the literature reviewed, the public health definition is also treated as 'real' and accorded a privileged status as factual, disinterested knowledge. For example, some of the studies cited quantitative findings to establish the significance of their empirical topic. In this register, the public health understanding is accorded a realness that is somehow beyond the symbolic order, beyond culture, almost 'objective', as natural objects might appear within the physical sciences. When the public health understandings of risk and harm are positioned as real in this way, achieving a convergence with emic understandings is a matter of crafting the public health message in a way that is compatible with local symbolic orders.

In some of the literature, public health understandings of risk and harm are presented as constructed in the sense that, according to the social constructionist maxim, 'all assessments are assessments relative to some standard or other, and standards derive from cultures' (Jarvie, 1983 p. 46). In this register, public health understandings are treated as another kind of understanding to be integrated into the macrosociological narratives achieved by the analytic process. This symmetry is apparent in Sheehan and Ridge's (2001) distinction between 'researcher-defined' risks and harms, and risks and harms perceived by their participants from a 'holistic' perspective. While there are some partial connections, overlaps and resonances between the public health and microsocial understandings of risk and harm, there are also some substantial differences. In the face of these differences, the literature reviewed practises a kind of ontological agnosticism. It does not try to resolve the differences one way or another so much as it looks for statements that transcend the differences and unite both symbolic orders within one macrosociological understanding. This technique avoids making direct statements about the ontology of risk and harm, but nevertheless implies that a greater integration between the public health and microsocial constructions of risk and harm would reduce the *actually real* risks and harms associated with drinking.

In either approach to public health understandings of risks and harms being ‘real’, this impulse to achieve convergence of understandings begs some important questions about the nature of the ‘real’. Does a drive towards convergence imply that the risks and harms of drinking are real and commensurate in all possible symbolic orders? If so, how does this fit with the social constructionist maxim that the substance user’s definition of the situation is *the* situation? If not, and risks and harms exist in some symbolic orders and not others, what kind of reality do risks and harms have within public health science? Has public health science played some role in making them ‘real’? Is there only one reality or are there multiple realities? If realities are multiple, why work to achieve a convergence between them? None of these questions are satisfactorily dealt with in the literature reviewed.

## **Conclusion**

In this literature review, I considered qualitative alcohol studies of young adults’ heavy sessional drinking from Australia in the last 20 years. I also introduced some international studies with bearing on the Australian literature. I began with the proposition that the sampling, data-gathering methods, analyses and findings of the literature were primarily oriented towards developing emic accounts, that is, statements about young adults’ heavy sessional drinking from the perspective of young adult drinkers themselves. Young adults’ heavy sessional drinking was inextricably bound into a game of winning, losing and otherwise negotiating social capital. Drinking practices take place against the backdrop of young people’s position in that game. Alcohol is useful for young adults to gain confidence and experiment with dynamics of transgression and control, and youthfulness and maturity, although the effects of these practices sometimes run counter to their intentions. I argue that the epistemological significance of these findings is grounded in social constructionist ontology, which holds that the meanings of things come from their place in a symbolic order, and that the substance-using subject is the final authority on the subjective experience of AOD use. From this ontological standpoint, the analytic method involves introducing empirical observations at different scales within a single analytic frame, and calibrating macrosociological statements that exceed the microsocial perspectives, but remain compatible with them. In the literature reviewed, these techniques highlighted the macrosociological forces of



changes in gender roles, class stratification and neoliberalism by showing them at work in microsocial contexts. In this respect, social constructionist analysis moves towards a convergence of different versions of the real, operating at different scales and in different symbolic orders. This is apparent in the treatment of risk and harm in the literature reviewed. Quantitatively based public health definitions of risk and harm stand in stark contrast to emic, microsocial understandings of risk and harm. Both understandings were taken as 'real', and convergence between realities was sought, but in the process, some deeper ontological questions about how risks and harms came to be real have been missed. These questions go to the very purpose of qualitative research on heavy sessional drinking, and for this reason, they form the primary concerns of Chapter 3.

## Chapter 3

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# The ramifications of science and technology studies

This chapter introduces science and technology studies (STS) and details its radically different approach to some of the questions posed by the social constructionist literature reviewed in Chapter 2. STS shifts research from a representational to a performative act. This means that research does not *discover* health problems, drug effects or the efficacy of certain treatments or interventions; rather, it *enacts* them. An STS-informed methodology requires research to attend to the material *and* the symbolic dimensions of its entities of concern. It animates the general within the specific, and identifies macrosociological forces within the intimate configurations of humans and objects. It recognises that the ontology and agency of the entities it studies are constantly in flux as they assemble and reassemble variously. It concentrates on understanding what assemblages *do* by mapping the interrelations between them, and tends not to be concerned with discovering what they *are* by discovering abiding essences. STS-informed research tries to include a wide cast of actors, actants and practices but it always recognises that causal accounts exclude many of the forces making things happen. It sees research as an inherently political act, making some configurations of the real more probable, and others less so. I will argue that the ontological questions raised by the social constructionist literature reviewed in Chapter 2 are not merely abstract philosophical tangents; rather, they put at stake the purpose of public health interventions in this field. I revisit these questions and demonstrate that the insights arising from STS provide compelling new responses.

During the 1980s a new disciplinary field began to emerge, building on two foundational works: Kuhn's 1962 *The structure of scientific revolutions*, and Latour and Woolgar's 1979 *Laboratory life* (Law, 2004; Mol, 2002). Insights from these and other ethnographic studies of scientific practice have been developed further and

assembled under the STS label (Demant, 2009). Philosophical antecedents to this movement include feminism, post-structuralism and post-colonialism, with particular reference to the works of Michel Foucault and Giles Deleuze. Much of what is known as STS work has also been referred to as ‘actor-network theory’, and has more recently been referred to simply as ‘science studies’ (e.g. Fraser, Moore & Keane, 2014) or ‘material semiotics’ (Law, 2009). STS analysis has extended well beyond the bounds of science per se and into ‘the messy thickness of social and political life’ (Baiocchi, Graizbord, & Rodríguez-Muñiz, 2013 p. 324), becoming a general social theory centred on technoscience (Sismondo, 2009).

Over the last decade, a growing number of researchers have begun exploring the implications of STS for the AOD field (e.g. Dilkes-Frayne, 2014; Duff, 2011, 2012a, 2012b, 2013; Farrugia, 2014, 2015; Fraser, 2006, 2013; Fraser & Moore, 2011; Fraser et al., 2014; Fraser & valentine, 2008; Fraser, valentine, & Roberts, 2009; Moore, 2011; Thomson & Moore, 2014; N. Vitellone, 2010, 2011) but its use in alcohol research is, thus far, quite rare (Bøhling, 2014, 2015; Demant, 2009; Fraser et al., 2014; Law & Singleton, 2003). Insights from STS provide some convincing responses to the questions raised in Chapter 2. As the questions on that list have some topical interrelations, I will consolidate them into three. In what way are risks and harms real if they’re understood differently in different symbolic orders? Is the job of qualitative research to achieve the convergence of different symbolic orders? What role has public health science played in making the risks and harms of heavy sessional drinking ‘real’?

The radical way STS responds to these questions has some very unsettling implications for social constructionist ontology. A broader explanation of the ramifications of STS is necessary before the questions can be answered. In the following sections, I tack between ontological and methodological ramifications of STS, and finally focus upon the political dimensions of research under this new regime. I then return to my three questions at the close of the chapter.

### ***Ontological ramifications***

In the previous chapter, I characterised alcohol literature as either qualitative or quantitative. Typically, the respective ontologies of these paradigms are differentiated as social constructionist and scientific realist. While this binary characterisation is well recognised, it overlooks a logic common to both, a logic ‘so deeply entrenched within western culture that it has taken on common sense appeal. It seems inescapable, if not downright natural’ (Barad, 2003 p. 806). Scientific realism and social constructionism share a commitment to what Barad<sup>4</sup>, and assorted theorists before her<sup>5</sup>, have called ‘representationalism’. Representationalism presumes two distinct types of entities: representations and that which is represented. It positions science, or good science at least, as the process of making accurate representations of already existing, independent entities. Scientific realist alcohol studies tend to represent alcohol as a pharmacological substance that acts to harm the health of the population. Social constructionist alcohol studies tend to represent alcohol as a prop in a performance of identity in relation to a group. While they may disagree on how alcohol is most accurately represented, each paradigm understands its task as a representative one, and each has developed a suite of methodological conventions for doing so. When properly followed, these methodological conventions are understood to serve as a window onto reality, allowing a clear and real vision of the entities represented (Law, 2011a). Representationalist epistemology rests on a broader ontological proposition that Law calls ‘Euro-American common sense realism’ (2011a p. 156). Law characterises common sense realism as resting upon six assumptions: that reality is *out there*, *independent*, *preceding* our actions or attempts to know it, *definite* in form, *singular* and *coherent* (Law, 2011a). Despite their status as common sense, these ontological tenets are a historical artefact of developments in Western philosophy which were and are contested. Scholars have

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<sup>4</sup> Karen Barad is a feminist science studies scholar, not an STS scholar *per se*. Her work is included here because of its congruence with STS propositions about ontology, and because of her lucidity in discussing the issues of concern.

<sup>5</sup> Barad lists those critiquing representationalism as ‘feminists, poststructuralists, postcolonial critics, and queer theorists’ (Barad, 2003 p. 804). She later draws attention to some ontological implications of quantum physics, particularly the work of Niels Bohr, which similarly displace representationalist assumptions (Barad, 2007).

worked to unearth this history<sup>6</sup> and advance a contrary theory. STS explicitly sets out to ‘wash away the metaphysics of common sense realism’, and to:

shift our understanding of the sources of the relative immutability and obduracy of the world: to move these from ‘reality itself’ into the choreographies of practice. (Law, 2011a p. 172)

Law’s use of the term ‘choreographies’ here implies a metaphor of multiple actors playing a role in a *performance* for effect. A body of ethnographic science studies literature, particularly from the decade after the publication of Latour and Woolgar’s (1979) *Laboratory life*, documents the practices of scientists, and their material and semiotic apparatuses, as they perform scientific facts (Baiocchi et al., 2013). These empirical accounts served to lay the theoretical grounds for more abstracted arguments about performative ontologies. Following this format, I will outline the argument with reference to two empirical examples.

The first example is Annemarie Mol’s (2002) study of atherosclerosis, a disease of the leg veins, in a single hospital in the Netherlands. Using ethnographic methods, Mol showed how the leg veins and their attendant disease emerged very differently from the various socio-technological assemblages handling the disease. In the clinic, for example, the veins were part of living bodies and the disease was indicated by pain on walking or by variations in blood pressure. In medical imaging, veins were images on computer screens or x-ray transparencies, and the disease was indicated by mathematical assessment of their geometry. In pathology, the veins were tissue removed from a corpse or from a living patient during surgery, and the disease was indicated by inner thickening. We might say that each area of the hospital had its own way of detecting the presence of the disease, but Mol wants to make a different point: that the semiotic and material practices of detecting the disease are precisely what defined its existence as such. She argues that the disease does not exist independently of the practices used to indicate its presence. Mol draws attention to the ontological inseparability of the practices associated with diagnosis and the

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<sup>6</sup> Barad (2003) cites the work of Michel Foucault, Judith Butler and Ian Hacking in developing this theme.

disease itself: atherosclerosis owes its existence as much to diagnostic practices as it does to 'diseased' leg veins. She pointed out that the different practices in the different departments of the hospital created different realities of the disease. These different realities had partial connections, complementarities and resonances with each other, but occasionally there were frictions and interferences between them. Mol documented the work done in the hospital to maintain atherosclerosis as a single object in cases where the diagnostic assemblages produced different indications. Mol demonstrated that atherosclerosis and leg veins were artefacts of the assemblages producing them. They were performed through practice, or, in her words, enacted. This emphasis on practices can be contrasted from a symbolic interactionist emphasis on 'culture' or the symbolic order of social worlds. The clinical practices that make atherosclerosis real include symbolic orders, but they also have material components: patients' legs and veins, and different arrays of diagnostic-technological equipment in the clinic, in medical imaging and in pathology. Each of these material components help to make atherosclerosis what it really is.

Another example, this time specifically concerned with enactments of drugs, is a study by Emilie Gomart (2002) entitled *Methadone: six effects in search of a substance*, which reviewed two clinical studies of methadone treatment: one in France and the other in the United States. She found that the differences in methadone's effects between the two sites could not be accounted for by differences in interpretation or by inherent properties of the drug. In the American experiment, methadone acted to block heroin craving, whereas in the French experiment, it acted to facilitate the interventions of a psychiatrist. To make sense of these different drug effects, Gomart shifted attention towards the theoretical and clinical assemblages enacting the drugs within the trials. Each action emerged from an assemblage enacting a particular drug use pathology. Methadone in each trial acted differently through an assemblage of different practices, and its effects varied as the practices varied. Gomart argued that the ontology of a drug cannot be understood in isolation from its effects; that is to say that a chemical compound becomes a drug when its effects are interpreted as drug effects, so the effects of a drug are ontologically inseparable from its enactment as a drug. This proposition is consonant with a broader move in STS to conflate what things *are* (the essence of things) with what

they *do* (their affordances and agential qualities). In the two trials considered in Gomart's study, the effects of methadone were mediated by the clinical assemblages in which it was deployed; which is to say that the clinical practices ontologically co-constituted the drug itself. Gomart concluded that methadone can only be defined ontologically in relation to the specific assemblages engaged each time in its enactment. Even entities which had seemed indivisible and foundational are shown to be achievements, shaped in and through practices (Gomart, 2002 pp. 97–98). This turns representationalist ontology upside down, proposing that practices deployed to investigate the properties of a substance co-produced those properties rather than merely revealed their prior existence. The implications of this insight for research on heavy sessional drinking among young adults are radical. If Gomart is taken seriously, then the risks and harms associated with heavy drinking practices are co-produced by the research methods used to investigate them. Further, the ontology of the substance—what alcohol really is—is also co-produced by investigations of it.

With this argument in place, I can respond to a question posed in Chapter 2: in what way are risks and harms real if they are understood differently in different symbolic orders? In light of the performative ontologies articulated by Law, Barad, Mol and Gomart, we can see that alcohol studies in the scientific realist (quantitative) and social constructionist (qualitative) conventions deploy socio-technological assemblages in enactments of what heavy sessional drinking is and what it does. Whether one or the other more adequately represents the risks and harms of heavy sessional drinking is beside the point, because representing reality is no longer the task. Rather, the task of scientific studies of alcohol use, whether quantitative or qualitative, is to perform alcohol effects. In doing so, the studies inevitably co-produce the effects they are investigating.

However, neither the social constructionist nor the scientific realist studies of alcohol use reflexively participate in the performance of alcohol effects. Being self-conscious about performing realities requires some methodological innovations, as does accommodating some other aspects of STS ontology. The methodological implications of STS are explored in the following section.

### ***Methodological ramifications***

If research methods have ontological implications for their objects of study, then we might ask: what research methods should be chosen? STS takes a permissive view of methodology, but a performative ontology does entail some epistemological maxims. These follow from an unconventional understanding of the relationships between subjects and objects; and between the specific and the general.

As we have seen, representationalism is an ontological paradigm in which each study is structured by a distinction between a pre-existing apparatus of investigation and an entity to be investigated. In this sense, it follows a dualist model of representations and entities represented, minds and bodies, subjects and objects, humans and non-humans. These distinctions have been expressed in divisions of labour between social science, which looks at the first half of each dyad, and natural science, which looks at the latter half (Latour, 2005). While the social sciences investigate the intentions, desires and imaginaries of human subjects, the physical sciences are left to monopolise investigations of the properties, structures and agential forces of objects in the physical world. In contrast, performative ontologies understand realities as being constituted by assemblages of representations and entities represented, minds and bodies, subjects and objects, humans and non-humans. More radically, a performative ontology collapses the fundamental distinctions between these binaries and insists that if the world looks as though it falls into these categories, ‘then this is because it is being done [performed] that way’ (Law, 2011a p. 156).

In place of dualism, STS advances a ‘flat’ ontology. Human subjects, social events, symbols, material objects and phenomena of all kinds are treated symmetrically. Material and ephemeral entities are all understood as emerging from an interrelated field of phenomena, and they are without fixed boundaries or identities until they are enacted through practices. One of the implications of this ‘flat’ ontology is that realities can no longer be credited solely to conscious subjects, as is the case within social constructionism, in which reality is constituted by social transmission of systems of signification between those who use them. Neither can the agency shaping realities be ascribed to physical objects in the world and their stable and



predictable properties, as is the case with scientific realism. Rather, realities and the many phenomena within them are socio-material. This means that a substance like alcohol always has physical properties (it is made of physical matter) *and* semiotic properties (it has significance as a symbol within a symbolic order), and these dimensions are always ontologically intermingled.

One implication of this flat socio-material ontology is that there is little point speaking of alcohol as though it acts in merely symbolic ways. Fraser et al. (2014) have pointed out that one of the critiques of social constructionist AOD studies emerging from STS-informed research has been the tendency to: ‘analyse drugs primarily as a rhetorical and political category, created through legal regulation and medical knowledge and deployed in order to distinguish normal from abnormal consumption.’ (p. 11)

An STS-informed inquiry into heavy sessional drinking would therefore distinguish itself from a social constructionist study by simultaneously attending to the agency of alcohol as a pharmacological *and* a symbolic substance. Overlooking the pharmacological effects of substances is common among qualitative studies (Demant, 2009), just as overlooking subjectivity is common in scientific realist studies, but an STS approach may identify both as agential forces of concern. To put it another way, we need to be sensitive to the non-human *and* human agents in any situation if we are to understand how and why things turned out the way that they did. Deploying this principle within her STS-informed research, Barad (2003) emphasises the term *matter*, and its meanings of ‘signification’ and ‘materiality’ (p. 801). If alcohol *matters* then its pharmacological *and* its symbolic properties need our attention. This means that alcohol itself is granted a measure of agency in STS-informed analysis, but this agency is always fully entangled with humans and their symbolic games. Methodologically, this means being sensitive to the actions of alcohol on pharmacological and semiotic planes.

Other sensitivities must be expanded too, if the methodological challenges of STS are to be met. For example, Duff, whose exegetical works (2011, 2012a, 2012b,

2013) have re-articulated pivotal STS insights for AOD research, suggested some matters of concern for the study of injecting drug use:

the presence of the drug itself as an agent; the human body amid other bodies; the needle and the syringe; cultural conventions governing the course of drug consumption; the spatial circumstances of the event ... among an everramifying throng of “actants” and agencies. (Duff, 2012b p. 271)

Here Duff included a symmetrical array of human and non-human agents at work in shaping events of intravenous drug use. The methods necessary to become sensitive to this array extend beyond the grounded theory-based thematic coding of social constructionist research, which is primarily about representing the symbolic structures of socially coded processes. Instead, Duff’s list reads like a catalogue of socio-material entities exerting agency in a momentary situation. The momentary situation is understood as simultaneously microsocial and intimate, with bodies, syringe and drug; and macrosociological, with cultural conventions and structures. Gone is the social constructionist dialectic tacking between micro and macro scales, and instead we have the folding of the macro scale into an intimate configuration of the biological human body, a drug and an intermediary device.

This defiance of traditional notions of dialectic and scale can also be found in Vitellone’s (2011) theorising of the syringe, which, she argued, is not a ‘dead device’ (p. 201) simply facilitating action between humans, rather it is entangled with the human and ‘fully alive’ to the events of addiction (p. 205). She advocated for research methods that allow the syringe to ‘speak’ (p. 205). This methodological animation of a tiny object is not an eschewal of the general in favour of the specific, but an unpacking of the general within the specific. A syringe may speak because it is theorised in STS as a socio-material hybrid entity. Large-scale forces can be located in small-scale objects and situations. This kind of entity is common in the STS-informed AOD literature, in which the fundamental unit of analysis is the subject-object (actor-actant, in STS terms) hybrid known as the assemblage. Thinking with the assemblage model is arguably the core methodological principle of

STS, but assemblage thinking is also inescapably ontological. The following section details the assemblage and its implications.

### ***An ontological and methodological tool: The assemblage***

The assemblage has been defined in various ways (cf. Duff, 2014). Fraser et al. gave the following account:

...the assemblage can be seen as an ad hoc cluster of knowledges, technologies, bodies and practices that contingently gather to form a temporary phenomenon, be it abstract or material. The world is made up of such assemblages, not of stable natural objects or self-evident, foundational concepts. (Fraser et al., 2014 p. 19)

In this definition, the assemblage is at once a hybrid entity made up of multiple constituent components and a kind of primordial monad. In this sense, the assemblage is a novel ontological precept. Perhaps the most novel implication is that an assemblage does not have stable properties predating its participation in events; instead its properties emerge as co-productions of the forces immanent to it. Just as Gomart (2002) argued that a therapeutic pharmacological substance was materialised in specific ways by clinical assemblages, all phenomena remain partly indeterminate until they are enacted through practices. This is just as true for substance-using subjects as it is for substances. For example, Fraser (2006) argued that the time and locations of drug use events can materialise particular drug-using subjects. This is to suggest that drug-using subjects are partly co-constituted by the drugs they use and the settings in which they use them. To apply the assemblage concept to drinking events, and combine the insights of Fraser with those of Gomart, is to say that alcohol effects are transformed by drinking settings and the subjectivities they co-produce, while drinking settings and drinkers' subjectivities are co-produced by the alcohol consumed. The ontological qualities of each of these entities emerge in their intersections with one another.

The assemblage is an ontological proposition about the entities with which qualitative research on heavy sessional drinking might concern itself. As noted

above, there is a tendency within STS-informed work to respond to questions about what things *are* through accounts of what they *do*. This means that in being an ontological model, an assemblage is also a model of causality.

Reviewing *After method* (Law, 2004), Duff summarised Law's approach to agency:

Law distributes or spatializes agency, attributing it both to (human) actors understood in a conventional sense, and to "actants" regarded as any nonhuman entity, object, substance, or process that makes a difference in a network of force relations or actions/behaviors. (2012b p. 271)

For Law then, as a model of agency/causality, the assemblage is a 'network of force relations' in which subjects, objects and practices intersect and co-constitute effects, and in so doing, co-constitute one another.

Significantly, the agency of an assemblage is not attributable to the sum of its parts. A causal model that is reducible to the sum of its parts is one in which each part has a stable and knowable agential character that remains unchanged by its being positioned in its present circumstances. Latour described a part of such wholes as an 'intermediary' that 'transports meaning or force without transformation: defining its inputs is enough to define its outputs' (2005 p. 39). In the assemblage model, the role of each actor and actant is understood not as intermediation but as mediation. For mediators, 'their input is never a good predictor of their output' because they 'transform, translate, distort, and modify the meaning or the elements they are supposed to carry' (Latour, 2005 p. 39). Causation is emergent rather than determined and belongs to the assemblage rather than to its components. In this context, Duff argued that it makes little sense 'to attempt to determine the degree of causality attributable to any one body, actor or object within a network, because the network produces activity as an emergent effect of all associations immanent to it' (2013 p. 168). In this causal model, the emphasis shifts from identifying the agency of individual agents (whether human or non-human) to identifying the plethora of entities at work in the assemblage and to the relations between them.

The assemblage, then, can be understood as an ontological and causal model that focuses empirical enquiry on the interrelations between component parts and their collective and emergent agential capacities. This stands in contrast to research that seeks to determine the causal influence of single entities, and in so doing, attribute to them specific and stable characteristics. In this way, STS-informed assemblage thinking has significant implications for the causal attributions of risks and harms arising from drinking events. The political significance of attributing risks and harms in AOD research, and the implications of STS for these attributions, are considered in the next section.

### ***Political ramifications***

Employing the notion of assemblages opens up new possibilities for understanding how alcohol acts upon drinkers in drinking events, and how a throng of actors, actants and practices transform the way it does so. STS scholars are keen to point out, however, that using assemblages as an ontological and methodological tool does not assure any transcendent access to complete or abiding truths. This takes us back to the notion of research performing realities rather than revealing them. Mol and Gomart demonstrated that practices deployed to investigate the properties of a substance such as methadone or a disease such as atherosclerosis co-produced those properties rather than merely revealed their prior existence. In this section I consider some of the political dimensions of making performative choices in the enactment of young adults' heavy sessional drinking.

The assemblages documented in STS-informed research are ephemeral and constantly in a state of disintegration and reformation. The interrelated actors, actants, and practices that comprise the assemblages of interest are themselves assemblages, and their constitutive interrelations spiral outwards to the  $n^{\text{th}}$  degree. Latour illustrated the point as follows: 'give me one matter of concern and I will show you the whole earth and heavens that have to be gathered to hold it firmly in place' (2004b p. 246). Circumscribing any matter of concern for the purposes of empirical research entails a truncation at a certain point, and these truncations might reasonably be made otherwise. As Law (2004) pointed out, for every entity made

present in a certain account, many more are necessarily made absent. While Latour (2004a) exhorted social researchers to populate assemblages as thickly as possible, he recognised that no grand account is possible, because fully accounting for realities is impossibly complex. The STS response is to identify a finite range of matters of concern. For example, in theorising the syringe, Vitellone (2011) identified needle exchange programs, HIV and needle-sharing practices as particular matters of concern. In doing so she did not argue that these elements of the assemblage can be used to represent the syringe, but that they can be used to enact (or perform) a particular reality of the syringe in the service of a political goal, in this case, improving the efficacy of public health policies in relation to infectious diseases common to injecting drug users. A different gathering of elements from the syringe assemblage would enact a different reality of the syringe, so any enactment is subject to contestation from a multiplicity of other realities. In this sense, STS draws attention to the ontological politics of social research—that is, the politics of the ‘real’.

For STS scholars, the delineations between individual actors and actants in any assemblage, and between their causes and effects, can be scientifically enacted in a multitude of ways. This approach to causality positions causes and effects as ontologically inseparable from epistemological practices. Latour argued that ‘causes and effects are only a retrospective way of interpreting events’ (2005 p. 39). To put it another way, when effects are ‘caused’ by alcohol use, systems for the definition and measurement of effects are as much a pre-condition for these effects as alcohol itself.

This observation suggests a response to a question I posed earlier in this chapter: what role has public health science played in making the risks and harms of heavy sessional drinking ‘real’? The answer is that public health science has selected a few forces from the plethora and made them accountable for the risks and harms associated with heavy sessional drinking. Other forces that might equally have been implicated were left out of the account, or in Law’s (2004) description, made absent. This is not to dismiss public health research: politically engaged research need not excuse itself for being partial, selective and methodologically mediated, since this is an inevitable characteristic of all scientific enquiry. It can purposefully select the

actors, actants and practices of concern that will be used in its enactment of the real, and it is among these entities that responsibility for the phenomena of concern can be distributed.

For example, Demant and Krarup (2013) showed how Danish research, policy regulation and public concern around adolescent binge drinking have worked in parallel to enact alcohol as an actant of moral and cultural significance. These enactments have reinforced a liberal regulatory regime and displaced enactments of alcohol as a socio-material actant with, among other things, long-term health effects. In light of the insights of STS, any distribution of responsibility is partial, methodologically mediated and contestable. Studies might more explicitly recognise their epistemological practices as participating in an ontological politics (Law, 2004; Mol, 1999) with political and policy implications.

Research can—indeed it must—absent the role of some forces from its enquiries and its causal attributions. For this reason, ‘method is not, and could never be, innocent or purely technical’ (Law, 2004 p. 143) and research is unavoidably political. Causal attributions have political implications. As Law (2004) puts it:

In its different versions it [research] operates to make certain (political) arrangements more probable, stronger, more real, whilst eroding others and making them less real. (p. 149)

Research can assist or frustrate certain political agendas by making some realities more real and undermining others. In light of this proposition, what have STS scholars provided in the way of normative guidelines to assist researchers in deciding what realities we ought to perform? Law (2004) asserted a responsibility to ‘truth’ in the sense of the veracity of the description. He also argued that there is a duty to accommodate multiplicity, since there are many practices crafting many realities. Latour echoed this call, saying we should treat research as ‘adding one more contrast, one more articulation’ (2004a p. 225). Since there are no primary qualities, ‘no scientist can be reductionist, disciplines can only *add* to the world and almost never subtract phenomena’ (Latour, 2004a pp. 225–226). In this sense, researchers ought to

seek out and employ new methodologies to generate new causal insights and broaden the repertoire of explanations.

In addition to these normative grounds established by STS scholars, other normative propositions can be found within the complementary field of post-structuralist AOD research. Moore (2002) made a similar argument to Latour in relation to studies of AOD use among ‘young people’. According to Moore, researchers in this field ought to:

continue challenging the already established drug-research disciplines by breathing new life into stale debate, objecting to simplistic research findings that justify widely held stereotypes, creating new subjects with new discourses. (2002 p. 53)

Moore’s injunction here is to push for an ever-growing array of explanations of drug use and its effects, along with ‘new subjects with new discourses’. The task of research is always to add a new articulation of truth, rather than to reify pre-fabricated truths as abiding or transcendent. In Chapter 2, I posed the question: is the job of qualitative research to achieve the convergence of different symbolic orders? I believe that the arguments of Law, Latour and Moore provide us with a resounding answer: no, on the contrary, the job is rather to achieve divergence and multiplicity.

Duff has also constructed some normative grounds on which STS-informed work in the AOD field might stand, with a similar focus on reconstructing the drug using subject. In his work reconstituting notions of health, illness and recovery through the ‘assemblage thinking’ of Deleuze, he argued that:

AOD use in ‘real experience’ does not involve a rational (or irrational) subject who comes to drugs as if in consideration of a problem; what to use, how much, when, where, with whom, for how long, why? These judgements are a function of the event of drug use, rather than the subject of this event. The subjectivities that are active in each drug event are distributed in and among an assemblage of human and



nonhuman bodies, spaces and affects. Subjects, as such, are expressed anew in each consumption event, sometimes subtly, sometimes profoundly. The locus of action is equally distributed, such that attributions of judgement or responsibility for the carriage of consumption habits must include a wide cast of bodies and spaces. (Duff, 2014 p. 142)

Here, we can infer that Duff is arguing for a decentring of the subject—and recognition of its multiplicity—in attempts to address problematic substance use. If all research is unavoidably partial, methodologically mediated and political, then it is incumbent upon STS-informed researchers to be explicit about the political agenda of their constructions; to make it clear what imperatives have been at work in deciding to make certain forces present and attributable, while absencing others and excusing them from responsibility. Duff suggested that one important political imperative for STS-informed AOD research is to de-centre the subject, and in its place to include ‘a wide cast of bodies and spaces’.

### ***Summary of STS ramifications***

STS shifts research from a representational to a performative act. This means that research does not *discover* health problems, drug effects or the efficacy of certain treatments or interventions; rather, it enacts them. An STS-informed methodology requires research to attend to the material and the symbolic properties of entities of concern. It animates the general within the specific, and identifies macrosociological forces within intimate configurations of humans and objects. It recognises that the ontology and agency of the entities it studies are constantly in flux, and it concentrates on understanding what assemblages *do* by mapping the interrelations between them, and tends not to be concerned with performing what they *are* by discovering some abiding essence. STS-informed research tries to include a wide cast of actors, actants and practices but always recognises that causal accounts neglect many of the forces making things happen. It sees research as an inherently political act, making some configurations of the real more probable, and others less so.

## Conclusion

In this chapter I introduced some of the tenets of STS, a set of theoretical and methodological propositions arising, initially at least, from anthropological studies of scientific practices. I demonstrated the departures, contrasts and incommensurability between the social constructionist literature reviewed in Chapter 2 and the emerging body of STS-informed AOD research. There are myriad differences between social constructionist and STS-informed AOD research: empirical focus on symbolic orders vs. arrays of actors, actants and practices immanent to the events of consumption; exclusion vs. inclusion of pharmacological action as an empirical concern; representationalist vs. performative ontology; and, ostensibly objective vs. explicitly political framing of purpose.

Another distinction between the two, the one hinted at in the title of Chapter 2, is the route from the specific to the general. Social constructionists compare observations of symbolic orders within different microsocial worlds in order to craft statements that hold true in each case, but exceed each case and become generalisable. Their aim is to jump from the micro to the macro and reveal the fundamental structures of human cultures and behaviours. STS-informed work, on the other hand, permits no jumps onto the structural, and instead always ‘clamps’ its explanatory chains to specific, observable actors, actants and practices (Latour, 2005 p. 174). As I suggested in the literature review, social constructionist analyses of young adults’ heavy sessional drinking have looked across data from microsocial worlds and separated them into constituent elements, thematising and distilling them into macrosociological forces such as gender, class, neoliberalism or globalisation. An STS-informed analysis, on the other hand, would hold events within the data together, and populate them as thickly as possible with specific empirical details. The STS analyst might observe that some of the actors, actants and practices within the events come from elsewhere; some of them might come from very distant times, places and symbolic orders. In order to explain a specific event or action here and now, analysts may have to shift their gaze over the horizon to elsewhere. So far, STS-informed AOD research has found the macro at work in a syringe; its design, manufacture and distribution systems operate at scale and so do its suppositions about the relations it mediates between drugs and bodies and between drug-using

bodies (Vitellone, 2004; Vitellone, 2010, 2011). It is in traversing these temporal, cultural, spatial or other planes that the STS analysis achieves its scale and animates the macro within the micro. These two paths from the specific to the general diverge, and from that divergence emerges the significance of my research project.

While there are dozens of studies considering the risks and harms and other implications of heavy sessional drinking practices among young adults from a social constructionist point of view, STS-informed investigations of these phenomena are, so far, scarce (Demant, 2009; Fraser et al., 2014; Law & Singleton, 2003). Demant's work explores early possibilities for applying the theory to the empirical topic of youth drinking, and is not specifically concerned with harms or socioeconomic stratification. Fraser et al. concentrated on 'addiction'; Law and Singleton focused on liver problems among chronic drinkers. In contributing an STS-informed multi-sited ethnographic study of young adults' heavy sessional drinking, my research makes a novel and significant contribution to scholarship in this area.

## Chapter 4

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# Methodology and the ethnographic field

My move away from the social constructionist tradition of alcohol research entails more than a different approach to analysing qualitative data: it brings scientific practices themselves into the analytic frame. When science is understood as performative, analysis of scientific practices can generate insights into how realities are brought into being and held in place. There are also opportunities to respond critically, and to question whether things might be better if realities were performed differently. Steve Woolgar, co-author of the canonical *Laboratory life: The social construction of scientific facts* with Bruno Latour (1979), has argued that STS is an ‘ongoing trajectory of provocation’ that aims to unsettle tacit assumptions about the nature of explanation (2004 p. 345). In keeping with this ethic, in this thesis I analyse several influential disciplinary constructions of heavy sessional drinking, and pose some awkward questions about what they make present and absent. By way of adding some contrasting examples, I also analyse my own qualitative data through the rubric of the assemblage, and argue that the socio-material networks in which young drinkers are enmeshed might equally be held accountable for the outcomes of drinking events. This chapter presents the methodological choices I have made along the way and details some of the theoretical and analytical resources I have adopted from prior research. It also contains an introduction to Broadmeadows, a Melbourne suburb where my more traditional ethnographic fieldwork took place. Applying STS-informed ontologies and epistemologies necessitated a complex web of methodological considerations, and this chapter on methodology is perhaps longer and more complicated than its counterparts in other monographs. As the implications of contemporary sociological theory become more commonplace in empirical studies, more streamlined methodological accounts may become possible, but for now, the complexity of my methodological account seems unavoidable.

As a qualitative study that takes as its field of enquiry both the meaning-making practices of professionals in several fields *and* the drinking practices of young adults, this thesis can be accurately described as a multi-sited ethnography<sup>7</sup> (Marcus, 1995). The following section addresses the meaning of this term and some of its epistemological and methodological implications.

### **Constructing the field and its sites: Multi-sited ethnography**

Ethnographic study is distinguished by having a ‘field’ in which the researcher spends an extended period to gain familiarity and understanding. In ethnographies of the classic cultural anthropological form, such as those by Hannerz (1969) or Geertz (1973), the field is a spatio-temporal zone with a defined linguistic, cultural and geographic character. This notion of the field can be contrasted with the model George Marcus (1995) introduced in his description of multi-sited ethnography. In this model, ‘fields have to be constructed and ... this process must be guided by theory on the one hand and by the imperatives of fieldwork on the other’ (Nadai & Maeder, 2009 p. 243). In Marcus’ newer model, one tries to map the ‘inherently fragmented, yet connected, spatial and social spheres of modern societies’ (Nadai & Maeder, 2009 p. 236). It is motivated by recognition that ‘the global is collapsed into and made an integral part of parallel, related situations, rather than something external to them’ (Marcus, 1995 p. 102). While a multi-sited ethnography necessarily affords less time to spend ‘in’ each site, and in that sense comes at the cost of what anthropologists might term ‘depth’, the spaces that provide the ‘locus of study’ are not themselves ‘the objects of study’ (Nadai & Maeder, 2009 p. 238). Instead, the object of study is itself the logic of common association between sites. The sites are all ‘locations and social situations where according to theoretical assumptions this object may be found’ (Nadai & Maeder, 2009 p. 243). In that sense, the co-location of distinct sites within a single field ‘defines the argument of the ethnography’ (Marcus, 1995 p. 105). The selection of sites containing the object of study is

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<sup>7</sup> While this study can accurately be described as a multi-sited ethnography, it does not follow that the qualitative data collected can be described as ethnographic in the traditional sense of ‘thick’ description.

theoretically driven, but each must be a site in which the object of study has ‘some significance for the members’ everyday lives’ (Nadai & Maeder, 2009 p. 246).

A multi-sited ethnography may also eschew a concern for finding *subjects* of study—in ethnography these are typically ‘natives’ (Nadai & Maeder, 2009 p. 236) or ‘subaltern subjects’ (Marcus, 1995 p. 101)—in favour of finding *objects* of study. The objects of study are often deliberately constructed in alternative, non-conventional ways (Hine, 2007). The object of study can be a thing, plot, narrative, allegory, biography, metaphor, circulating idea or conflict (Marcus, 1995, 2012). Marcus (1995) cited Latour’s (1988) study of pasteurisation as an exemplar of the ‘follow the thing’ mode of multi-sited ethnography. He also suggested that Martin’s (1994) study of ‘immunity’ in the mass media, on the street, in the treatment of AIDS, among alternative practitioners and among scientists is another example of the ‘follow the thing’ mode of multi-sited ethnography. In these studies ‘immunity’ and ‘pasteurisation’ are not one thing but many. Their reality in some sites may be incommensurate with realities elsewhere.

Once sites have been identified and the ‘field’ constructed, analysis proceeds comparatively and looks for ‘contrasts and similarities’ (Nadai & Maeder, 2009 p. 243) along with ‘juxtapositions of phenomena that conventionally have appeared to be (or conceptually have been kept) “worlds apart”’ (Marcus, 1995 p. 102). As with Mol’s atherosclerosis or Gomart’s methadone, partial connections, overlaps and resonances are brought to light, but so are the frictions and dissonances between instantiations of the object.

With these descriptions in place, I can now meaningfully state that my study of heavy sessional drinking among young adults is in the mode of a ‘follow the thing’ style multi-sited ethnography. In the following sections I describe the sites constituting my field.

## **Introducing the sites and the analyses of heavy sessional drinking within them**

Thrift (2008), whose ontological standpoint shares much with STS, suggested that a site is an ‘actualisation of times and spaces’ and ‘an insertion into one or more flows’ (p. 12) rather than a concrete encounter with a stable geographic space. Such an understanding leaves room for many possible ways of arranging the sites gathered together here. Each site in this chapter has webs of relations with each of the others, so the demarcations between sites might reasonably have been made otherwise. The sites listed here represent a purposeful gathering of elements. Some are made here from purely textual resources; others have a geographic locus and are made here from qualitative data. Some are drawn together from a combination of these elements. In addition to encounters with the object of study in various sites, this thesis detours into bodies of related literature for the purposes of benefitting from, or contrasting with, related scholarship. These bodies of literature are not presented here as sites but as resources to help interrogate the field.

Since the goal of this chapter is to characterise the methodology of my study as well as the ethnographic field, where relevant, sites presented here have an accompanying description of data-gathering techniques and the analytic techniques used.

The sites constituting the ethnographic field of this thesis are:

- Broadmeadows and its sub-sites,
- alcohol epidemiology concerned with morbidity and mortality,
- young adult drinking events,
- Commonwealth and Victorian alcohol policy between 2001 and 2012,
- the Broadmeadows Bats Football Club, and
- the Northern Suburbs Alcohol and Other Drugs Clinic.

The selection of these sites has been guided by the research questions I introduced in Chapter 1: how are heavy sessional drinking and its problems currently enacted in significant sites of research, policy and service provision? What are the effects of these enactments? How else might they be enacted? Each of these sites, and my specific rationales for their inclusion, is presented in order in the following sections.

### ***Broadmeadows: a geographic locus***

The geographic locus of this study was Broadmeadows, a socioeconomically disadvantaged suburb close to Melbourne's outer northern edge. As mentioned in Chapter 1, an ethnographic focus on the City of Hume, in which Broadmeadows is located, was mandated by the epidemiological component of the Australian Research Council (ARC) Discovery Project DP110101720, with which my PhD research was associated. I chose to focus on the Broadmeadows area within Hume because it was readily geographically accessible and closely aligned with my interest in heavy sessional drinking among socioeconomically disadvantaged young adults. This is an interest to which I return in the final section of this chapter.

Analysis of historical documents and research on the area (Faulds, 2002; Hunt, 1996; Lemon, 1982; Wyatt, 2009) suggests that the development of Broadmeadows was a Keynesian government project to improve the circumstances of low-income people and build the industrial economy. In the early post-war era the state and federal governments succeeded in attracting heavy industry and housing those who migrated to the area, but for decades afterwards failed to provide for their suburban amenity. Overcrowded schools, a lack of public and commercial facilities, sustained migration from non-English-speaking countries, heavy transport through the middle of the suburban development, and the predominance of public housing all had consequences for the economic and social character of Broadmeadows. A consultant's report commissioned by a Federal Government development agency reported in 1976 that: 'Broadmeadows has become popularised as a less-than-sought-after area, devoid of many community facilities and generally having an unattractive environment' (Lemon, 1982 p. 190). While further public and private investment flowed into the area during the 1980s and 90s, this was constructed under a new post-industrial, neoliberal regime that repositioned the suburb as peripheral to economic and cultural life in Melbourne and Australia more broadly.

According to figures for the State of Victoria for 2011–12, the proportion of the population who consumed alcohol at levels posing 'short term risk of alcohol related harm' at least once in the past 12 months was 52.6%; the figure for the Victorian



City of Hume, in which Broadmeadows is located, was substantially lower, at 39.3% (Department of Health, 2014 pp. 56–57). Rates of ‘alcohol-attributable events’ were also lower in Hume in than in Victoria as a whole. Comparable figures for Hume and Victoria in 2011–2012 are provided in Table 2.

**Table 2 - Rates of alcohol-attributable events in Hume and Victoria, 2011-12**

<b>Rate per 10,000 population, 2012–2013</b>	<b>State mean</b>	<b>Hume</b>
alcohol hospital admissions	43.7	27.6
alcohol Emergency Department presentations	13.0	9.3
alcohol ambulance attendance	30.5	25.8
access alcohol, drug and information service	52.6	33.2
alcohol death rate	2.3	1.0
serious road injuries during high alcohol hours	4.6	2.7
assaults during high alcohol hours	15.3	13.6
alcohol family violence incidents	26.7	17.9

(Turning Point, 2014)

However, concerns about the drinking practices of young adults, particularly those from Muslim backgrounds, have been voiced in the community (Hume City Council, 2011 p. 26; Kayhan, 2008). According to demographic data (Australian Bureau of Statistics, 2012b), nearly half (47.4%) of Hume’s residents were born overseas and, after English, the most common languages spoken at home are Arabic (13.4%) and Turkish (12.9%). Catholicism and Islam are the two most popular faiths, with the Catholic population being notably older than its Islamic counterpart. According to the metric used by the Australian Bureau of Statistics, Broadmeadows is in the most disadvantaged 10% of statistical local areas nationally. In December 2014, the State MP for Broadmeadows said that the unemployment rate was 26.4% (Hastings & Savino, 2014). In 2007, the percentage of ‘disengaged’ people (defined as ‘those who were not attending any educational institution and were unemployed’ p. 21) aged 20–25 years was calculated to be 21%, compared to 12% elsewhere in Melbourne (nlt consulting pty ltd, 2007 p. 27). At the time of the 2011 census, the most common industries of employment were manufacturing (15.5%), transport, postal and warehousing (10.8%) and retail trade (10.5%). Persons employed in manufacturing

in 1996 numbered 6,637, while the comparable number in 2011 was 3,296, a reduction of more than 50% in 15 years (Australian Bureau of Statistics, 2000, 2012a). The proportion of workers employed in manufacturing and associated industries looks set to fall further, after Ford Australia announced in 2013 that it was to cease manufacturing at its Broadmeadows plant in 2016, shedding 1,200 jobs from its plants in Broadmeadows and Geelong (The Drive Team, 2013).

### ***Field observations***

Data collection in Broadmeadows commenced in October 2012 and was completed in August 2013. It included interviews with young adult drinkers, interviews with social service professionals and field observations. All observations and interviews were conducted by me and all data were collected in accordance with the ethics procedures approved by the Curtin University Human Research Ethics Committee (Approval Number HR108-2012). For reasons of anonymity, all participants and locations (except Broadmeadows itself) are presented here pseudonymously. The following sections outline the data gathering methods in turn.

Field observation data totalled around 45,000 words. Field observations were overt and all reasonable efforts were made to ensure that participants were aware of the research. I carried plain language statements and university ID with me to all field locations and provided them to those I observed whenever practical. The primary purpose of field observations was to connect with young adult heavy sessional drinkers, and the service professionals handling them, in order to conduct participant observation and interviews. While field observations were conducted in many sites across Broadmeadows, sites of concerted focus included the Dallas Brooks Mall, North Park Estate and Community Centre, licensed premises, and Southmeadows Youth Services. My work in these sites is detailed below.

### ***Dallas Brooks Mall***

Dallas Brooks Mall was my first field site focus, and I visited most days during October and November 2012. The site was selected because it was an outdoor civic and retail space through which locals frequently passed on foot, and in which an

outsider might unobtrusively observe daily activities. The weather at that time of year was warm and dry, so time could be spent outdoors with little discomfort. A small independent bottle shop<sup>8</sup> was also an attraction. Visits would typically begin at around 10am, when I would arrive by car. I would usually stay at the mall for around two hours before venturing elsewhere, and would most often return for further observations in the afternoon. During the early days of my data gathering at Dallas Brooks Mall I spent time walking around the laneways behind the mall and surrounding suburban streets, seeking evidence of alcohol consumption and trying to orient myself to local geography. While I found a few broken bottles and rubbish bins containing empty alcohol packaging, I detected few other traces of young adults' heavy sessional drinking in the area. During one of these walks, I encountered a young woman in her front yard. I introduced myself and initiated a conversation. After chatting for a minute, I explained my study and asked if she might be interested in participating in an interview. She seemed willing, but asked that I return later so that I might interview her partner at the same time. I explained my sampling criteria (defined later in this chapter) and she told me that she thought she was eligible. Later that afternoon, and after explaining the plain language statement and observing the other ethics procedures, I conducted an interview with the couple, sitting in their front yard. During the interview it became apparent that neither had participated in heavy sessional drinking in the past 12 months, so were not eligible for inclusion in the sample. I nevertheless continued the interview and instead focused on their reasons for not drinking heavily. During the following weeks I would often see them around the mall, but despite my requests, I was unable to secure any referrals from them to other eligible participants.

After the first few visits, I spent less time investigating the broader area and more time in the mall itself. I noted that most of the mall visitors I judged to be in the 18–25-year-old group spoke Arabic and were visibly Islamic (the men were bearded and the women wore headscarves and long dresses). I knew that Islam is typically interpreted as forbidding alcohol, so I did not concentrate my data-gathering efforts on this group. In hindsight, I might have made more effort, because as the data presented in Chapter 6 suggest, some young adult Muslims do not abstain from

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<sup>8</sup> A licensed take-away liquor retail outlet

drinking. Instead, I came into contact with some older residents, mostly of Anglo-Australian—in local argot, ‘Aussie’—appearance and speech. I found that my being an ‘Aussie’ helped me to be readily accepted into this group. My hope was that accessing this group might lead to contact with a cohort of young drinkers. I connected with this group primarily through a man who could be found most days outside the bottle shop in the mall, asking passers-by for change so that he might purchase beer and cigarettes. This man became an ethnographic ‘gatekeeper’ (Agar, 1996) of sorts, and introduced me to other locals who frequented the mall.

By way of data collection, I would return to my car every hour or two to record field notes by hand in a journal. This allowed me to maintain awareness of the comings and goings outside while affording the opportunity to write in a quiet, sequestered space. My field notes concentrated on phenomenological data, including descriptions of the foot traffic, my recollections of what I and other people had said during conversations, and descriptions of people I had met or observed. At times I would also note my thoughts and feelings about how the fieldwork was progressing, and record speculations about the dynamics of young adults’ heavy sessional drinking and related practices.

After a few weeks I had documented interactions with 25 regular mall visitors, but experienced little success in meeting young adult drinkers. I began to vary the hours of my visits, trying early and late evenings and some weekends. These visits also failed to draw any positive results. After five weeks, I began to focus my field observations elsewhere.

### ***North Park Estate and Community Centre***

The North Park Community Centre is located within the North Park Estate, a medium density cul-de-sac of townhouses that the Victorian Office of Housing owns and manages. The North Park Estate and Community Centre was my second major field focus. I visited a few times per week between February and August 2013. I interviewed 11 young adult heavy sessional drinkers at the Community Centre. This section describes the circumstances and procedures for gathering these data.

My engagement began in December 2012, on a recommendation from a research colleague who had contacts in Broadmeadows. ‘Hal’, an employee of the community centre, agreed to meet me there. After showing me around the Centre and describing its operations, Hal participated in a 75-minute interview as a social service professional participant and demonstrated great interest in ethnographic research on the estate. Hal offered to assist me to identify potential participants for my interviews and participant observation, so I began to visit the Centre regularly. During these visits I would sometimes meet suitable candidates incidentally, and sometimes meet them as a result of an introduction from Hal. Hal also made arrangements for me to access meeting rooms at the Community Centre to conduct the interviews. On several occasions Hal and I travelled through the estate together on foot, chatting with residents and observing life there. Hal also invited me to attend the monthly meeting of a committee of staff from government agencies with an interest in the estate, and I accepted. During these meetings I met service professionals whom I subsequently recruited for interviews. In all these respects, Hal served as a significant ‘gatekeeper’ to the Community Centre and the Estate.

### ***Licensed premises and liquor outlets***

Field observations were conducted in four public licensed premises, and a fifth was observed during the day from outside. On three occasions, observations involved purchasing a beer and sitting for a while, observing unobtrusively. The other occasion involved a walkthrough to observe the layout and scope of activities on offer. Observation occasions included ‘watching the Cup’ on Melbourne Cup Day (traditionally a heavy drinking occasion in Melbourne), three night-time visits, and one daytime visit. Young adults’ heavy sessional drinking was not observed during any of the visits. Data from these observations are briefly presented in Chapter 5.

Broadmeadows has a plethora of bottle shops, most of which are attached to supermarkets. Others are small independent or large department-store-sized operations owned by dominant Australian supermarket corporations. Observations of most packaged liquor outlets in Broadmeadows were conducted during the fieldwork. The largest and busiest was a branch of First Choice Liquor, where several of my interview participants had purchased alcohol for the drinking events

studied. Its prices were notably cheaper than nearby competitors' and its range was comprehensive, including a wide selection of prestige products. My observations indicated that its busiest time was mid–late afternoon on weekdays, particularly on Fridays, as workers picked up supplies on their way home. A typical customer was male, arrived in a trade utility vehicle, and purchased cans of bourbon and cola products.

### ***Southmeadows Youth Services***

One service professional and two young adult heavy sessional drinkers were recruited at the offices of Southmeadows Youth Services. These contacts were made after I contacted the agency and was allowed to place a recruitment flyer in the waiting room. Data from an interview with the dyad of young adult heavy sessional drinkers are presented in Chapter 6.

### ***Interviews with young adult heavy sessional drinkers***

The sampling frame for young adult heavy sessional drinkers required participants to be 18–25 years of age, to live in or spend a significant proportion of their time in Broadmeadows, and have consumed at least 11 standard drinks if male or nine standard drinks if female in a single session at least once in the past year. This sampling frame was aligned with the requirements of the epidemiological component of the ARC Discovery Project. Data collection with the young adult heavy sessional drinkers included 10 interviews with lone participants and three dyad interviews, yielding a sample of 16 interview participants. Prior to recruitment for interviews, each participant was screened with the question 'do you sometimes have a big drinking session?' During the ensuing discussion I made it clear that a 'big drinking session' entailed 'about' 10 standard drinks, and that I sought people who had consumed that quantity on a single occasion in the previous 12 months. If potential participants responded in the affirmative, I informed them that interviews would take about one hour and that they would be compensated AUD\$40 (USD\$30) for their time. During interviews with three participants, it became apparent that they had not drunk heavily in the past 12 months, but interviews were continued and I explored the reasons for not drinking heavily.

When interviews were paired the dyads were well known to each other, either as family, partners or co-workers who sometimes socialised together. Dyad interviews afforded mutual convenience and descriptions of drinking events from multiple perspectives. Ethics protocols included all interview participants being provided with a written plain language statement and, on some occasions, verbal explanations of the research. All participants were given the opportunity to ask questions and have them answered, and were informed that they may withdraw their consent at any time without repercussions. Interviews were recorded on a digital device and, on each occasion, participants stated on the recording words to the effect that: 'I have been given information about the research project on drinking. I agree to participate and I give Aaron Hart permission to record information about me'.

Interviews were semi-structured and began with questions about the participants' connection to the Broadmeadows area and to the organisation hosting our meeting. I then asked participants to 'tell me a bit about' themselves, and in the ensuing conversation sought to elicit details about their family, occupation, housing circumstances, age, religion and schooling. After the background details had been gathered, I asked participants about their 'last [most recent] big drinking session'. During the ensuing conversation, I sought to elicit details about:

- who they were with;
- the location[s] of the event;
- what prompted the session;
- transport to the event;
- activities at the event;
- alcohol products and quantities consumed, and what they may have liked or disliked about their chosen product;
- how and when they had purchased the products and their approximate cost;
- any other drug use at the event;
- the time spent drinking;
- the time and circumstances of the conclusion of the event, and;
- how they felt the next day.

In some interviews this pattern of questioning was repeated for multiple events. After event details had been gathered, I then sought some more general information about participants' drinking:

- how often they have a big drinking session;
- if many of their friends drink;
- anything they liked about drinking and any perceived drawbacks;
- if they had been in trouble because of drinking, and;
- any history of other drug use.

Interviews took about 45 minutes.

### ***Interviews with social service professionals***

The sampling frame for service professionals required participants to be employees and volunteers with social service agencies operating in Broadmeadows or surrounding areas. Recruitment involved making contact with a snowball sample of service professionals and volunteers in the area. I conducted 13 interviews with lone participants and one dyad interview, yielding a sample of 15 participants.

Interviews took place in participants' work sites, which were mostly offices. I began interviews by asking participants about the host organisation, its history and values, and their duties within it. As the conversation developed I would also seek details about the participants' disciplinary backgrounds and any training, study, or personal values shaping their service practices. I would then turn the conversation towards participants' clients, seeking to elicit details about their demographics, presenting issues and perceived service needs. In particular, I enquired about clients' alcohol use, and any ways in which service delivery responded specifically to these practices. I also sought details about any criteria used to establish eligibility for services and the funding arrangements for service provision, with particular interest in any ways in which reporting requirements to funding agencies shaped the work undertaken with clients. These lines of enquiry were designed to inform me about the roles played by bureaucratic apparatuses of measurement and definition in shaping the phenomena of young adults' heavy sessional drinking. I then sought more specific



details about the participants' work with clients, what it entailed and how it made sense of clients' AOD use practices. I asked participants about their perceptions of Broadmeadows and any changes they had noted in heavy sessional drinking, other AOD use practices and related aspects of life in the area. Finally, I asked participants if there were any drinking-related topics that they would like to know more about, and if there was any way my research could inform or support the work of the participant and their organisation. Interviews with social service professionals took about one hour. Some of the data from interviews with service professionals is presented in Chapters 7–9.

With the qualitative data gathering methods specified, I now outline the methodological procedures specific to each of the sites comprising my multi-sited ethnographic study.

## ***Alcohol epidemiology concerned with morbidity and mortality***

The first site presented in the thesis is made from textual sources. In selecting an alcohol research field for inclusion as an ethnographic site, I chose a quantitative, scientific realist orientation because the bulk of alcohol studies fall within these parameters. Of the quantitative fields, I selected alcohol epidemiology because, as I will demonstrate in Chapter 5, it plays a crucial role in structuring the ‘alcohol’ entity to which public health policy and clinical practices respond. Alcohol epidemiology takes a range of different forms, including cohort or population studies, studies of trends in statistics, and analyses of mortality data. Of these, I selected the alcohol epidemiology concerned with morbidity and mortality because of its focus on attributing alcohol with harmful effects, a recurrent theme in this thesis. Within this field, I selected a specific, landmark text on which to focus my analyses: an early quantification of alcohol ‘caused’ mortality and morbidity, authored by English, Holman, Milne et al., published in 1995.

In particular, I examine English et al.’s (1995) designation of different entities into the categories of *sufficient* and *component* causes. I draw attention to the simplification of causation within this model, and the way it purposefully ranks, selects and deletes entities within the array of causal phenomena. I identify those elements of English et al.’s methods and findings that subsequent Australian and international studies have referred to as methodological and taxonomic reference points. I follow the initial performance of alcohol as a *cause* of morbidity and mortality in the population to its later status as a stable reality, enabling a host of other propositions about alcohol’s causal properties to be held in place. Finally, I observe the political effects of these scientific practices, noting some of the forces in alcohol assemblages that have been absented from the causal frame and overlooked as possible targets for intervention; of these, I highlight socioeconomic disadvantage. This ethnographic site of alcohol epidemiology concerning morbidity and mortality is detailed in Chapter 5.

### ***Young adult heavy sessional drinking events***

In Chapter 6, I counterpoise the alcohol research site with an account of young adult heavy sessional drinking made from qualitative data gathered during interviews with young adult heavy sessional drinkers.

While epidemiology figures alcohol as acting on a population, and social constructionist qualitative literature figures themes across multiple drinking groups and contexts, STS-informed AOD studies tend towards detailed descriptions of individual events. Analyses of events are useful for understanding the agency of alcohol assemblages because events are ‘occasions given to different entities to enter into contact’ (Latour, 1999 p. 141).

As has been argued earlier, it is in the intersection of different actors and actants that the agential characteristics of alcohol assemblages are formed. Events are temporally and spatially specific arrangements of forces that change in detectable ways. Dilkes-Frayne (2014) characterised the drug use event as a ‘*process of successive mediations*’ (p. 445) and argued that an events focus brings together ‘the social, spatial, material and temporal aspects of drug use, while remaining sensitive to the complex and dynamic nature of these relations’ (p. 446). Drinking events have a particular duration, include specific individuals and occur in given locations, all of which transform their outcomes. Tracing the chains of causal flow between these actors, processes and relations is therefore a central element of any analysis of drinking events. However, the forces at work in drinking events may also include those which are spatially and temporally distant to the event in focus. In an example provided by Dilkes-Frayne (2014 p. 446), the forces at work in an event of drug use at a music festival can include previous occasions on which the drug was used, experiences at previous festivals attended, the purchasing and availability of the drug, the contexts and expense of purchasing the ticket to the festival, the musical acts booked to play at the festival, and so on. These actions take place at some temporal and spatial distance from the drug use event in focus. Latour (2005 p. 186) also suggested that events can have multiple changes of scale and plane, and that events involve the time, place and people in question, as well as the constellation of forces that act within it, many of which are temporally and spatially distal.

Following this model, transcriptions from audio recordings of interviews with young adult participants were initially drafted into a series of ‘figurations’,<sup>9</sup> each detailing a single drinking event as thickly as possible. Figurations included an account of the participant and their circumstances, an event, and a characterisation of some of the actants and actors driving change in the event. Particular attention was paid to detecting the changes that were significant for interview participants and following the forces that drove them.

After it was developed, each figuration was imported into NVivo and a typology of actors and actants in the event-assemblages was developed. The next step was to analyse the agential characteristics of particular types of actors and actants over the whole of the dataset. As this process developed, a web of interrelations began to form between a few types of actant and actor types. Using nine event case studies adapted from the figurations, these webs of interrelations are presented within three patterns of relations in Chapter 6.

### ***Commonwealth and Victorian alcohol policy between 2001 and 2012***

The research questions for this study required the selection of an area of alcohol policy as an ethnographic field site. According to Loxley, Gray, Wilkinson, Chikritzhs, Midford and Moore (2005 p. 560), there are at least seven favoured areas of alcohol policy. These are:

- pricing and taxation;
- regulating the physical availability of alcohol;
- modifying the drinking context;
- drink-driving countermeasures;
- regulating alcohol promotion;

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<sup>9</sup> According to Braidotti (2002), figurations are ‘...materialistic mappings of situated, or embedded and embodied, positions... A figuration renders our image in terms of a de-centered and multi-layered vision of a subject as a dynamic and changing entity’ (p. 2).

- education and persuasion strategies (in communities, homes, schools and work-places); and
- treatment and early intervention.

It is evident from this list that alcohol policies span a wide range of governmental scales (from national laws governing advertising to municipal planning laws governing licensing) and modes of governing (direct state law enforcement in traffic policing, to taxation, and nuanced governmentality through education syllabus and clinical treatment). In Marcus' (1995) definition of multi-sited ethnography, ethnographic fields are constructed in part by the imperatives of fieldwork. While the possible targets for study were many, I was limited to an area of policy that closely intersected with the qualitative data I had available in order to mount a contextualised and situated analysis of a policy's actual impacts, and counterpoise its official rationale. Given the data collection opportunities that had emerged through my encounters with the Broadmeadows Bats football club (detailed below) and the public policy-driven attempts to change drinking culture at the club, I investigated a range of national and Victorian policy documents for their engagement with the idea of 'drinking cultures'. I discovered that, over successive generations of policy development, efforts to change drinking cultures had moved from the periphery to the centre of policy concern. I found a policy document immediately pre-dating what I identify as the contemporary focus upon 'drinking culture' and followed its successors, at the Victorian state and Australian governmental levels, until their most recent iterations. Armed with these insights, I set about constructing the Commonwealth and Victorian alcohol policy documents between 2001 and 2012, and the focus on drinking cultures within these documents, as an ethnographic site and as a vehicle for responding to the research question concerning alcohol policy.

In my analysis of seven policy documents, I use textual analysis techniques to consider the shifting meaning of 'drinking culture' and the associated shifts in policy initiatives to alter it. The documents were imported into NVivo qualitative analysis software, and a coding scheme was developed after reading each document closely. In my coding, I catalogued the various entities that were used to co-constitute 'drinking cultures', definitions of the 'drinking culture' concept, and the various

scales of affiliation these enacted. I also attended to population subgroups of drinkers identified in the documents as having particularly problematic drinking practices, and the intersections between these groups and notions of ‘drinking cultures’. In Chapter 7, I follow the successive constructions of ‘drinking culture’, paying particular attention to what is gained and lost along the way.

### ***The Broadmeadows Bats***

To counterpoise the enactments of ‘drinking culture’ in policy documents, I detail drinking cultures in a Broadmeadows football club subject to a policy-led initiative for culture change. Both sites feature in Chapter 7.

The Broadmeadows Bats football club was a field site for one interview with a dyad of service professional participants, and one observational visit to a football game. I learned of the club and their efforts to change their drinking culture through a police officer I met during a committee meeting at the North Park Community Centre. The clubhouse, carpark and playing field each played a role in the drinking cultures practised among club members. During the interview with participants at the Broadmeadows Bats clubhouse, I used a modified version of the service professional interview schedule. The field visit involved attending a game at the club’s home oval in which the Bats’ senior team competed. During the game I stood on the boundary as a spectator and observed unobtrusively. I completed my field notes at home afterwards.

The interview transcript and observations was imported into NVivo and analysed for evidence of the drinking cultures of the club and initiative to change them. For reasons outlined in Chapter 7, drinking cultures are theorised as being held in place by shared sensitivities and common webs of connection between human and non-human elements, at various scales of affiliation. My analyses also pay particular attention to the entanglement of hegemonic masculinities within these webs of connection.

My analyses of the interview transcript and field notes follow the evolutions of drinking cultures in the club, and identify the webs of relations at work in generating change and stability.

### ***Clinical and public health science and the Northern Suburbs Alcohol and Other Drugs Clinic***

The research questions for this study required that I investigate a significant site of service provision responding to heavy sessional drinking among young adults. In my interviews with service professionals in Broadmeadows, I encountered a wide range of professionals involved in such service provision, including a housing worker, an employment services manager, a community development manager, youth workers, police officers, a social worker employed in a welfare office, an educator, AOD clinicians and an AOD clinic research officer. The interviews with each of these participants offered different enactments of young adult heavy sessional drinking, each of which might have been a fruitful avenue for analysis and critique. However, I needed to select a site of service provision that corresponded to a body of related qualitative data sufficient to allow the construction of a counterpoising site. My opportunities to conduct field observations within the Northern Suburbs Alcohol and Other Drug Clinic (NSAODC) provided me with this element. In addition, Mol's (2002) STS-informed work in a clinical setting had given me some enthusiasm for applying her methods for my own purposes and a similar enthusiasm from my primary supervisor, David Moore, also had some influence. For all these reasons, clinical and public health science within the NSAODC became the chosen vehicle for responding to the service provision element of my research question.

Just as the actions of epidemiology and alcohol policy are significant because of the scale on which they operate, clinical treatment of alcohol use by young adults occurs widely, with at least 795 publicly funded AOD treatment agencies operating across Australia in 2013–14 (Australian Institute of Health and Welfare, 2015).. Australia's use of publicly funded AOD treatment agencies is increasing, with 118,741 individual clients entering treatment in 2013–14, an 8% increase from the previous year. In 40% of all treatment episodes in these agencies, alcohol was designated as the primary substance of concern. A similar proportion of treatment episodes were

for clients aged less than 30 years (Australian Institute of Health and Welfare, 2015). No specific figures for the treatment of heavy sessional drinking among young adults are available. My data suggest this practice is deemed to be of clinical concern if it coincides with significantly disadvantaged life circumstances or legal proceedings or both. Forensic treatment represented 17% of publicly funded treatment episodes nationally in 2013–14 (Australian Institute of Health and Welfare, 2015).

Unlike the preceding combinations, this disciplinary site and its counterpoising site made from my qualitative data are folded into one another in such a way as to require their mutual inclusion within the same body of text. I analyse the science that structures the abstract and generalised realities practised in AOD clinics through observations of situated practices in a single clinic. However, the practices in that clinic very often resist, defer or complicate the scientific enactments they ostensibly deploy. By following these controversies, this final ethnographic site encompasses both the influential discipline's enactments of young adults' heavy sessional drinking, and a situated context in which these enactments are challenged. This site is presented and analysed in Chapters 8 and 9.

My first contact with the NSAODC occurred after an internet search indicated that they provided clinical AOD services to young adults in Broadmeadows and the surrounding areas. A clinician providing these services agreed to an interview in November 2012. During the interview, I expressed interest in attending clinical review meetings and interviewing other clinicians. The clinician introduced me to a service manager and, after providing documentation explaining the details of my study, my requests were approved. I recruited other NSAODC staff into the service professional sample through a snowball method. Three of the interviews were conducted in offices at the NSAODC's head office and one in an office in Broadmeadows, where a clinician conducted his work with clients. These interviews were conducted between November 2012 and February 2013.

When waiting for interviews in the waiting area, I sometimes perused the pamphlets, booklets and forms provided to clients. I collected some of these for later analysis. During interviews, conversation would sometimes turn to procedural, diagnostic and



administrative dimensions of clinical work. On these occasions, I requested copies of pro-forma documents clinicians used. These documents, and their enactments of heavy sessional drinking and other drug use, are included as data within the NSAODC site.

Observations took place at the head office and in an adjoining youth withdrawal service, beginning in December 2012 and concluding February 2013. These field visits focused on observations of clinical review meetings. Clinical review meetings were held daily and typically involved between five and 10 clinicians gathering in a meeting room and taking turns to introduce the details of a client assigned to them. The details typically included information about a client's AOD treatment history, their accommodation, employment and family circumstances, presenting and historical mental health problems and treatment, and other medical, psychological or welfare services they might be receiving. The purpose of clinical review meetings was to develop a treatment plan for each client. During my observations, I sat at the meeting table without participating in the conversation and wrote notes in a journal, recording as much detail of the conversation as possible.

Because some of the clinical review meetings I observed took place in the youth withdrawal unit, I was able to observe some of the other interactions there between staff and clients. These included sitting in on a harm reduction workshop, a family therapy information session, and general conversations with clients. Prior to my participation in these events, all participants were provided with plain language statements outlining my study and given the opportunity to ask questions and to grant or deny consent verbally. Each participant was invited to withdraw their consent at any time, without fear of repercussions.

Analysing these data initially involved importing transcripts of the interviews, field observations and documentary evidence into NVivo. All data were coded into a 'situation analysis' qualitative coding scheme, the root nodes of which were drawn from the system developed by Clarke (2005). Subsequent nodes were developed analytically from the data as the data were coded into them.

Overall, the significance of the arguments in Chapters 8 and 9 emerges from the counterpoints between two ethnographic sites, with the clinical and public health science on the one hand, and the NSAODC with its case study client on the other.

To provide a structure for the presentation of data, an exemplary case study was chosen. By tacking between this case study, other qualitative data, and broader propositions from clinical science, I detail several controversies about the ontology of alcohol and other drugs and the clients who use them. Theoretical justifications for this style of analysis are outlined in Chapter 8, and further analyses are offered in Chapter 9.

### **Data analysis and politics**

In my analysis of some of the sites above I bring the practices of scientific research, policy formation, and clinical AOD work into the analytic frame and consider how they perform and reinforce particular realities. In the analysis of the sites in which I collected qualitative data, I make my own, contrary causal assertions. In contrast to the causal models employed in the disciplinary sites, I use the causal model of the assemblage to attribute responsibility for the effects of drinking events. This section comments on the politics of this approach.

Taking an assemblage approach to analysis requires an explicit recognition that the accounts offered are necessarily partial and incomplete. Race quoted Michael (in press) as saying ‘we cannot hope to be exhaustive in accounting for all the elements [in causal assemblages]...but we can at least begin to trace some of the complexities entailed in them’ (Race, 2014 p. 21). As pointed out in the previous chapter, for every entity made present in a certain account, many more are necessarily made absent. My case studies implicate socioeconomic marginalisation in the wake of de-industrialisation; the neoliberal economic and normative environment in which this has taken place; victimisation of sub-cultural groups and discourses of masculinity; family, ethnicity and memory; and drinking settings such as houses, parks, and a football club. This list of entities—and all of those left out of it—have been significantly determined by my selection of research questions, methods, theory, field sites and analysis. These have in turn been selected in accordance with my own

political commitments. These commitments are the subject of the remainder of this section, and their disclosure is a requirement of the ontological politics performed by my research.

My PhD research has been animated by an abiding interest in social justice. Prior to beginning my PhD studies, my research work included projects on youth homelessness, unemployment, economic development and social work case management. My approach to each of these topics was primarily concerned with improving the circumstances of those who find themselves on the margins of contemporary power regimes.

In the present study, one contemporary power regime in particular—neoliberalism—has been of particular concern. Notions of ‘risk’ and ‘protective factors’ are frequently deployed in research concerning young adults and their AOD use, and there are examples in research concerning Broadmeadows (e.g. Asquith, 2012 p. 25; nlt consulting pty ltd, 2007 p. 3). For sociologist Paul Kelly (Kelly, 2006), discourses of risk are entangled with broader normative agendas concerning the ‘entrepreneurial self’. For Kelly, the entrepreneurial self is an effect of neoliberalism, an ideology in which ‘[t]he game of enterprise is a pervasive style of conduct, diffusing the enterprise-form throughout the social fabric as its generalised principle of functioning’ (Kelly, 2006 p. 23 citing C. Gordon, 1991 p. 42). In this ideology, subjects ‘should forever be open to and responsive to signals—from the markets, from risks and dangers, from opportunities’ (p. 24). Some ‘risk-taking’ practices among young people represent their failure to respond appropriately to signals, and thereby missed opportunities to optimise their self-making enterprises. Through its association with ‘risk’ discourse, heavy sessional drinking is often understood in this light. Beyond their ‘risky’ practices, young adults’ occupational category and class status tends to be interpreted as the result of their personal negotiation of risks and opportunities rather than as the result of their reproduction of pre-defined roles, as was more common during the ‘Keynesian’ era (Wyn, 2012 p. 274). ‘Uncertainty of employment’ is a ‘key characteristic of the socio-historical conditions that this [current] generation’ of young adults face (Wyn, 2012 p. 274), leaving the reproduction of employment roles more elusive. Wyn (2012) and McDonald (1999)

both argued that young adults have tended to bear the brunt of neoliberal economic reforms, and are more likely to be unemployed or underemployed than their older counterparts in the contemporary labour market, and that in this context, neoliberal ideology tends to locate the effect of these structural forces with the individual and their failure to adequately develop their self-enterprise. To counter these realities I have committed to a causal model that brings socio-material structures into the analytic frame as a causal agent.

Law says of methodology: ‘In its different versions it operates to make certain (political) arrangements more probable, stronger, more real, whilst eroding others and making them less real’ (Law, 2004 p. 149). In light of this insight, I aim to ‘erode’ neoliberal realities and their tendency to attribute harm to individual choices, and instead make political arrangements that respond to structural disadvantage ‘more probable, stronger, more real’.

Within the AOD field, my political purpose is to equip researchers, policymakers and service providers with a broader repertoire of causal models on which to base their interventions to reduce alcohol-related harms. In addressing the literature, policy settings and clinical context, I aim to reveal the ways in which the individual subjects, or the alcohol they consume, have been positioned as the central causal agents in events of alcohol-related harm, while the other agents in the network have served, in Latour’s words, as a mere ‘backdrop to the flows of causal efficacy’ (2005 p. 128) or have been absented entirely. I aim to make these kinds of causal accounts less plausible, and to erode the political arrangements they underpin.

It is also necessary to make explicit my approach to enacting the ‘harms’ associated with heavy sessional drinking. The enactment of alcohol harms is an inherently political, ethical and normative process, although it often appears self-evident and grounded in corporeality. As I demonstrate in the following chapter, intense consumption is often treated as a harm in itself, but this is not my approach. Bøhling (2015) argued that a normative basis from which to assess AOD use assemblages is one in which ‘A good encounter [with AOD] increases the subject’s capacities to assert agency, feel and operate in the world, and a bad encounter decreases these

potentials' (p. 134). Duff (2014) made a similar argument, suggesting that such assessments might add empirical grounds to research concerned with the 'social determinants of health' among AOD users. He argued that, in such studies, the 'social determinants' are typically 'everywhere and nowhere' (p. 3) and as a result, causal claims are usually vague and epistemologically weak. In contrast, the assessments Bøhling and Duff propose must be sensitive to the cultural, material and affective nuances of specific events of AOD use, and would necessarily include effects upon the biological, psychological and interpersonal subjectivities of the AOD consumer. As such, this mode of assessment transcends traditional bifurcations in research attending to the 'social' or 'health' consequences of drinking. By moving outside this binary, an assessment might trace the interplay between social forces and alcohol-related harms. In this study, cases meeting Bøhling's criteria for 'bad encounters', that is, those that decrease a subject's capacities to assert agency, feel and operate in the world, are treated as harmful.

While this events-based style of normative analysis is designed to draw in a throng of actors, actants and social forces, in most cases presented here, it does so through the use of interview material. This technique has within it a political claim about the epistemology of subjective accounts. Analyses of interview data have followed the maxim that poststructuralist research practice does not present qualitative data as a 'true' account of an 'authentic' subject, or assume that research subjects speak from outside of pervasive ideological and scientific discourses. Instead, data are treated as a co-production of a 'research-data-participants-theory-analysis' assemblage (Mazzei, 2013 p. 732). From this perspective, qualitative data can allow a researcher to 'map out connectives, to think about how things worked together' (Mazzei, 2013 p. 736). This is the approach I have taken in analysing my empirical material.

## **Conclusion**

This thesis is presented as a multi-sited ethnography. I construct a theoretical ethnographic field by assembling an array of socio-material sites, in each of which the heavy sessional drinking of young adults is a matter of concern. Some of the sites presented in the thesis are disciplinary and authoritative: alcohol epidemiology concerning morbidity and mortality, government policy concerning drinking

cultures, and clinical practices. Enactments of heavy sessional drinking in these sites are analysed, and some of their effects are assessed.

Contrasting these enactments are accounts of heavy sessional drinking in Broadmeadows, a post-industrial, multi-cultural and socioeconomically disadvantaged suburb close to Melbourne's northern fringe. Within this geographic area, I gathered qualitative data in an open-air retail shopping mall, a public housing estate and associated community centre, a football club, licensed premises, a youth services agency and an AOD clinic providing services to those in the area.

The co-location of distinct sites within a single field 'defines the argument of the [multi-sited] ethnography' (Marcus, 1995 p. 105). Analysis of the qualitative data gathered in Broadmeadows and its sub-sites is used to construct causal accounts contrary to those deployed in the disciplinary sites, in order to pursue a political goal: the positioning of socio-material networks, rather than drinkers or alcohol, as the central causal agents in drinking events.

## Chapter 5

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# Alcohol and alcohol effects: Constituting causality in alcohol epidemiology

In this chapter I argue that the epidemiological study of alcohol mortality and morbidity undertakes several processes of simplification to enact order and make useful statements about alcohol and its effects. First, it constitutes alcohol as a stable pharmacological agent that acts consistently and independently and causes quantifiable effects. Second, this type of epidemiology focuses on populations in order to make the effects of alcohol observable and therefore a target of public health initiatives. Third, while this type of epidemiology understands social or other relevant ‘factors’ as amplifying or diminishing the intensity of alcohol consumption, it leaves the relationship between alcohol and its effects unchanged. This final effect is explored through analysis of literature concerning causal relationships between alcohol morbidity and mortality, low SES and employment or unemployment. As Mol and Law (2002) have argued, while all knowledge practices—whether they be epidemiological, psychological or sociological—must necessarily simplify if they are to enact order and make useful statements about complex issues, the distinctive political effects of these processes of simplification are rarely considered. In this chapter I begin to address this oversight.

There are, of course, different types of alcohol epidemiology (e.g. cohort or population studies, studies of trends in statistics, and analyses of mortality data), but I restrict my analysis to the identified type rather than to other types of alcohol epidemiology. I question some of the dominant realities constituted by this type of alcohol epidemiology, its assumptions about what alcohol is and what it does, and

the scientific authority and legitimacy granted to such work, as well as some of its political effects.

Central to my analysis are Law's (2011a) notions of 'choreographies of practice' and 'collateral realities'. As I noted in Chapter 3, STS explicitly sets out to 'wash away the metaphysics of common sense realism' and to shift our understanding of the sources of the relative immutability and obduracy of the world from 'reality itself' to the choreographies of practice (Law, 2011a p. 172).

In this chapter, I draw on Law's (2011a p. 162) typology of five practices involved in the choreography of realities: *juxtaposition*, *ranking*, *selection*, *deletion* and *framing*. *Juxtapositions* are processes of boundary setting between categories of things; they determine taxonomic distinctions such as 'natural' and 'social' sciences, or 'human' and 'non-human' entities. *Ranking* refers to the application of hierarchies of salience, which is necessary to guide the *selection* of those entities eligible for enactment and those subject to *deletion*. For example, juxtaposition, ranking and deleting occurs in quantitative social research in the identification of particular relationships between factors as statistically significant, or in qualitative research in the identification of core themes in the data. Each of these practices depends on a wider *framing* in which a host of realities, whose immutability and obduracy are assumed, are implied within the performance in question. Evidence of this process can be found in the literature review section of research publications, in which authors situate their inquiries within the field of already established methodologies, principles and knowledge. Law's typology directs our focus away from the question of whether research adequately represents reality and towards the question of how and why particular, partial and methodologically mediated realities have been enacted in the ways that they have been. It brings to light the contested political and philosophical positions always more or less implicit in scientific epistemology and methodology.

Law's (2011a) notion of 'collateral realities' is of particular significance to my analysis of the epidemiology of alcohol-related morbidity and mortality. Collateral realities are 'backstage assumptions' (Law, 2011b p. 493)—that is, those that appear incontestable and therefore beyond debate. They are realities that:



get done incidentally, and along the way. They are realities that get done, for the most part, unintentionally. They are realities that may be obnoxious. Importantly, they are realities that could be different. It follows that they are realities that are through and through political. (Law, 2011a p. 156)

Furthermore:

If reality appears (as it usually does) to be independent, prior, definite, singular or coherent then this is because it is being done that way. Indeed these attributes or assumptions become examples, amongst others, of collateral realities. (Law, 2011a p. 156)

For Law, the stabilising role of collateral realities is crucial because ‘it is the endless enactment of collateral realities that tends to hold things steady’ (2011a p. 172). Identifying collateral realities and the inconsistencies and tensions between these stabilising practices and the realities they perform offers a useful entry point for questioning existing accounts and offering new ones. The notion of ‘collateral realities’ was first applied in the drug field in Fraser’s (2013) analysis of obesity and the neuroscience of addiction, and elaborated upon in Fraser et al.’s (2014) analysis of changing definitions of addiction. It is central to my argument that English et al.’s (1995) initial performances of causality enable subsequent articulations about the health effects of alcohol upon the population. This argument is presented below.

### **The epidemiology of ‘alcohol-caused’ morbidity and mortality**

Epidemiology takes the improvement of population health to be its primary concern, and most epidemiological analyses of alcohol use and its effects focus on health risks (Demant, 2013; Keane, 2009). I begin my analysis by focusing on a landmark text in the type of alcohol epidemiology concerned with morbidity and mortality, that of English and colleagues (1995). There are good reasons to treat this report as a key site in the constitution of causality. Described as a ‘seminal work’ in an international review of research investigating the relationship between alcohol consumption and

the global burden of disease, published in leading scientific journal *Addiction* (Rehm et al., 2010 p. 818), the report's methodology and findings have had a lasting legacy, with 695 citations in Google Scholar (search conducted on 16 June 2015) and reiterations appearing in studies of the costs, harms and patterns of alcohol use in Australia and in Sweden (e.g. Chikritzhs et al., 2003; Collins & Lapsley, 2008; Laslett et al., 2011; Sjögren, Eriksson, Broström, & Ahlm, 2000). English et al.'s method for assessing 'the evidence of causality between alcohol consumption and disease outcomes' was also used in a WHO report on the Global Burden of Disease project (Rehm et al., 2004 p. 34). An exhaustive international summary of alcohol research, described as the 'alcohol policy bible' (Babor et al., 2010 p. 8), draws on English et al.'s epidemiological findings on alcohol consumption and heart disease (p. 121) and breast cancer (p. 125); it also cites other articles that employ English et al.'s model of causality (e.g. Jürgen Rehm et al., 2009). English et al.'s (1995) methodology has been revised for some diseases but has remained mostly intact in an updated version of the publication, authored by Ridolfo and Stevenson (2001).

In explaining some guiding principles for the etiology of AOD morbidity and mortality, English et al. stated:

The term "drug caused" is used in preference to "drug related" or "drug associated" because it is considered that the connection between deaths and morbid events so described, and the drugs to which our enquiry directed, is correctly expressed as causal. (1995 p. 6)

In determining that causation is an appropriate characterisation of the relationship between AOD use and mortality and morbidity, English et al. drew on a body of theoretical work within epidemiology. Causality is a topic of significant conjecture within epidemiology (Ward, 2009). According to Abbot (1998), common points of difference in models of causation include: singular versus multiple causes; necessary versus sufficient causes; rational action versus mechanical determination; simultaneous versus sequential ordering; and deterministic versus probabilistic agency. Room and Rossow highlighted the significance of these differences of theory in the alcohol field when they noted that: '[w]hile analysts have differed on whether

alcohol causes crime, the differences primarily reflect varying definitions of causation' (2001 p. 218). English et al. applied a model of causation first proposed by Rothman, which he described as an 'intuitive base for causal thinking' (Rothman, 1976 p. 591). For Rothman:

A cause is an act or event or a state of nature which initiates or permits, alone or in conjunction with other causes, a sequence of events resulting in an effect. (1976 p. 588)

In Rothman's model, disease arises from 'sufficient causes', which typically comprise multiple 'component causes'. Component causes of interest may be necessary (without which the disease would never occur) or unnecessary (without which the disease would still sometimes occur). Both are of epidemiological interest if they frequently co-occur with the disease. Using Rothman's model, English et al. elaborated the specific causal relationship between alcohol and other drugs ('drugs') and their effects: 'in the amounts usually consumed, drugs are component causes rather than sufficient causes of death and illness', and 'except for conditions defined on the circular basis of their cause, drugs are rarely, perhaps never a necessary cause of death and illness' (1995 p. 6). Rather than identifying necessary causes, the task of epidemiology in Rothman's model is to identify component causes of 'public health importance' (1976 p. 588), that is, those factors or conditions that are present in a high fraction of disease instances in a given population. Rothman performed a permissive definition of 'cause' which could conceivably include just about anything.

Applying Law's typology of stabilising practices to English et al.'s etiology, we can see that 'causes' in Rothman's model are not selected or ranked—this process is instead deferred to the designation of agents of 'public health importance'. Here, the salience of various agents must be performed via a fraction of disease instances in a given population. Most causes will be deleted, and a few selected for the attention of public health practitioners. Alcohol's designation as an agent of public health importance was to a great extent already achieved by the performance of the study itself.

There are, however, competing theories of causation in epidemiology. For example, the Bradford Hill criteria are used for justifying a move from observing a statistical association between phenomena to a verdict of causation (Ward, 2009). The nine criteria—consistency, strength, specificity, temporal relationship, coherence of association, gradient, plausibility, experiment and analogy—are deemed to provide ‘the context for making a logical, albeit non-deductive and non-inductive, inference to a hypothesis that (best) explains the facts’ (Ward, 2009 p. 16). According to their author (Hill, 1965, cited in Ward, 2009 p. 14), the Bradford Hill criteria assist researchers to determine if there ‘is any other way of explaining the set of facts before us, is there any other answer equally, or more, likely than cause and effect?’ The Bradford Hill criteria constitute ‘arguably the most commonly-used method of interpreting scientific evidence in public health’ (Weed, 2004 cited in Ward, 2009 p. 6) and establish a strict test for any agent to pass before it is deemed to be a ‘cause’ of disease. English et al. did not explain why they chose Rothman’s model of causation from among those available, and we might speculate on the political implications of using the Bradford Hill criteria and failing to demonstrate that alcohol is a ‘cause’ of disease in this stricter sense. In any case, those encountering English et al.’s categorisation of alcohol as a ‘cause’ of disease without familiarity with Rothman’s model might credit the term ‘cause’ with undue significance as a result of the hegemony of the Bradford Hill criteria.

Epidemiology does not typically attempt to understand causal mechanisms in their entirety, but attempts to identify causes nearest to the specified outcome and most amenable to practical intervention (Krieger, 1994). In order to isolate the causal agency of alcohol among the assemblage of agents potentially involved, English et al. used aetiological fraction methodology and provided the following justification:

Because of incomplete knowledge or inability to identify other component causes, it is often difficult or impossible to determine in which individual cases of death or illness a drug was a component or cause. In such cases, the causal relationship between adverse health effects and drug use must be expressed in terms of a probability

measure known as the aetiologic fraction. These fractions underlie most of our calculations of drug caused death and morbid events.

(1995 p. 7)

Aetiological fractions are calculated in two steps: the first is to establish ‘relative risk’ and the second to apply it to the population. In the alcohol field, relative risk is the risk of harm among drinkers relative to the risk of harm in abstainers or low-volume drinkers, and is established by studies of the prevalence of certain diseases or conditions in both cohorts. Often, meta-analyses rather than single studies are used to determine a pooled estimate of the relative risk. For example, Ridolfo and Stevenson (2001), whose study updated some of English et al.’s (1995) findings, used data from 39 international studies to show that the aetiological fraction attributable to drinking for breast cancer among females aged 18 and over was 0.121 (12%). In this first move, English et al., and Ridolfo and Stevenson, refigure agents such as alcohol as ‘risk-factors’ and causation is located instead with disease, as classified by the WHO’s International Classification of Diseases (ICD-9).

Once relative risks have been calculated, the second move is the translation of relative risk into effects at the population level. Ridolfo and Stevenson explain the process as follows: ‘a probability measure of the likelihood of causation by the risk factor... [is] applied to the total number of deaths, illnesses or injuries resulting from a specific cause’ (2001 p. 2). This process often involves aggregating the various classifications of disease into more general categories. For example, Ridolfo and Stevenson (2001) did not give a figure for female breast cancer specifically but found that, in 1998, 485 cancer-caused deaths among Australian females were ‘attributable’ to alcohol use (p. 97). The use of the term ‘attributable’ here is crucial—it resolves the ambiguity around alcohol’s status as a component cause and elevates it to the status of a necessary one for the 485 cancer cases.

### ***Stable agents, intermediaries and populations***

Let us consider these moves to stabilise alcohol’s causality from the perspective of Law’s (2011a) choreographies of practice. First, alcohol is *juxtaposed* with all the other components of a sufficient cause of disease and thus performed as a stable,

individuated pharmacological agent. Second, alcohol is *ranked* and *selected* as an agent of public health importance by the performance of the study itself. Third, the other component agents (in a sufficient cause of death or disease) are *deleted* from the causal equation through relative risk calculations such as the 12% figure for breast cancer. Finally, by applying the relative risk to the population and deducing the ‘attributable’ mortality and morbidity figures, alcohol is performed as out there, independent, preceding our actions or attempts to know it, definite in form, singular and coherent (Law, 2011a). Through a choreography of practices, a reality of alcohol as a cause of death and disease has been performed and stabilised.

English et al. (1995), and the studies that draw on this work, perform three collateral realities of alcohol. First, alcohol is enacted as a stable pharmacological agent that acts independently and consistently and produces quantifiable effects. With this reality stabilised, subsequent studies and reviews take alcohol’s status as a cause of death and disease to *frame* their further propositions.

For example, consider the following statement from Australia’s NHMRC: ‘Alcohol consumption accounted for 3.3% of the total burden of disease and injury in Australia in 2003’ (2009 p. 27). To develop these figures, the NHMRC used English et al. as a source of the injury categories for which alcohol has an ‘accepted causal effect’. In the international context, the WHO report on the Global Burden of Disease project cited earlier states:

alcohol-related burden of disease is considerable: 3.2% of global mortality and 4.0% of the global burden of disease measured in [disability-adjusted life years]. (Rehm et al., 2004 p. 12)

Both of these statements contain reifications of English et al.’s (1995) performance of alcohol’s agency. Once it has been quantified, alcohol’s agency is rendered immutable, stable and ready to be deployed as a fixed substrate in further elaborations.

The second collateral reality emerging from the epidemiological enactments of alcohol under examination here is that its effects are most visible at the population level, rather than in individual cases, and therefore a worthy target of public health initiatives. English et al. (1995) recognised that ‘it is often difficult or impossible to determine in which individual cases of death or illness a drug was a component or cause’ so instead they used probability measures at the population level to characterise alcohol’s agency (English et al., 1995 p. 7). Krieger (1994) distinguished the causes of health effects at the population level from those in individuals, and argued that insights from epidemiological research are not necessarily applicable to individuals. Rothman (1976) was careful to point out that his model aims to inform public health at the population level, and cannot be meaningfully applied to individual cases. This is because it does not focus attention on components with a universal basis, or in other words, necessary causes. Indeed, Rothman acknowledged that ‘the occurrence of disease in any individual involves a collection of component causes which constitute a sufficient cause that is unique, by its complexity’ (1976 p. 592). The implication here is that while alcohol acts on individuals in complex ways, it acts on populations in simple ways, calling into question the meaningfulness of epidemiological research for individual members of populations. Despite this limitation, population data are routinely used to advise individual drinkers, such as in the case of the NHMRC’s (2009) *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. The realist conception of a population is as a scaled-up representation of multiple individuals, but in light of the insights of STS, a population is an entity whose existence is mediated by epidemiological science as much as it is by the collection of individuals it seeks to represent. A population is an abstraction emerging from a choreography of scientific practice. Mol (2002) identified differences and frictions between treatments of benefit to populations and treatments of benefit to individuals. In principle, she wrote, we can do both, but in practice, public money, limited as it is, can only be spent once, and therefore difficult choices must be made about what kinds of entities we are treating.

The third collateral reality emerging from the epidemiological constitution of alcohol effects, one that helps hold in place the first two and is held in place by them, is that social or other ‘factors’, such as socioeconomic status or geographic location, are

understood to amplify or diminish—in Latour’s terms ‘transport ... without transformation’—the force of alcohol effects. But these factors are held at arm’s length from causation; it is only alcohol that causes alcohol effects. Instead these intermediary factors are related to alcohol effects via their influence on the volume and frequency of alcohol use. The next section explores the dilemmas associated with applying this proposition to the relationships between employment, low SES and alcohol-related harms.

### ***Low SES, unemployment and alcohol-related harms***

Some figures for alcohol’s relationship to employment, or ‘labour force status’, are given in an Australian study that deploys epidemiological findings in its methodology. This study was commissioned by the Australian Institute of Health and Welfare (AIHW), a statutory body charged with reporting the state of the nation’s health; as such, it has a direct role in informing the development of public health research and policy in Australia. The AIHW’s *2010 National Drug Strategy Household Survey* reported that:

employed people were more likely than unemployed people or those not in the labour force to drink at levels that placed them at risk of ... alcohol-related injury on a single drinking occasion (30.4% at least yearly but not weekly, and 20.1% at least weekly). (2011b p. 59)

To develop these figures, the AIHW used the NHMRC’s figures for the number of drinks per occasion. The NHMRC’s figures, as I mentioned above, are based on English et al.’s injury categories. In these results, the relationship between employment and the health effects of concern can be characterised in the following steps: (1) employed people were more likely to drink heavily on single occasions, and (2) those who were more likely to drink heavily on a single occasion were more likely to sustain an ‘alcohol-related injury’ (where alcohol-related injuries are constructed through relative risk methodology). Employment here does not have a direct causal relationship with the health effects in question, rather it serves an intermediary role—to amplify or diminish the volume of alcohol consumed. The AIHW (2011) report constitutes the causal relationships between alcohol, health



effects and a range of other ‘social characteristics’—such as education, main language spoken at home, SES, geography, marital status, and Indigenous status—in a similar way. These factors are also understood to amplify or diminish alcohol consumption rather than having direct causal relationships with health effects.

Tacit acknowledgement of this kind of relationship is evident within the many recent publications in which alcohol consumption is taken as a proxy for harm. A special edition of the journal *Drug and Alcohol Review* provides several examples (e.g. McKetin, Chalmers, Sunderland & Bright, 2014; Miller et al., 2014; Østergaard & Skov, 2014). This causal model has attained the status of being common sense; however, it runs out of explanatory power when relationships between a population’s alcohol consumption and its alcohol-related mortality and morbidity are demonstrably non-linear. Literature on interrelations between SES, alcohol consumption and alcohol-related harms present us with this kind of scenario.

A comprehensive suite of epidemiological studies of associations between SES and alcohol-related harms originates from Finland. The research has explored relationships between: alcohol, smoking and trends in life expectancy among different income groups (Martikainen, Mäkelä, Peltonen & Myrskylä, 2014); an alcohol price drop in 2004 and morbidity and mortality in different socioeconomic groups (Herttua, Mäkelä & Martikainen, 2008; Mäkelä, Herttua & Martikainen, 2015); the drinking patterns of socioeconomic groups and their alcohol-related mortality and hospitalisations (Mäkelä & Paljärvi, 2008); and different measures of SES and alcohol-related mortality (Mäkelä, 1999). In addition to the Finnish research, studies of socioeconomic differentials in alcohol harms have been conducted in England and Wales (MacDonald & Shields, 2004; Siegler, Al-Hamad, Johnson, Wells & Sheron, 2011), Sweden (Hemström, 2002), the EU (Bloomfield, Grittner, Kramer & Gmel, 2006), and Victoria, Australia (Lloyd, Heilbronn & Matthews, 2014). All of these studies found that alcohol-related morbidity and mortality were more severe among those with lower SES.

As proxies for SES, these studies have used manual and non-manual labour (Mäkelä & Paljärvi, 2008), employment and unemployment (Lloyd et al., 2014; MacDonald

& Shields, 2004), area disadvantage (Lloyd et al., 2014), income (Mäkelä et al., 2015; Martikainen et al., 2014), and education, occupational class, spending power and housing tenure (Mäkelä, 1999). On each of these measures, alcohol-related morbidity and mortality was found to be greater among lower-SES groups. One study including five dimensions of SES found that while income made the greatest difference, each further dimension added to the differential effect (Mäkelä, 1999).

These differentials have been enumerated in different ways. In Martikainen et al.'s (2014) study, for the period 2003–2007, Finnish men in the highest income quintile lost 0.9 years of life expectancy due to alcohol, while those in the lowest quintile lost 4.8 years. Women in the highest income quintile lost 0.3 years and in the lowest quintile lost 1.6 years. Mäkelä and Paljärvi (2008) found that, in Finland, the 'hazard of an alcohol-related death was 2.06 fold among manual workers compared with non-manual workers' (p. 730). In England, men with no qualifications were found to be 'more likely to experience the physical symptoms of alcohol' (MacDonald & Shields, 2004). An Australian study (Lloyd et al., 2014) found that 'the most disadvantaged groups were significantly more likely to experience hospitalization due to [wholly alcohol-attributable chronic diseases] and [partially alcohol-attributable chronic diseases]' (p. 4); and 'in 2006, the likelihood of being a [wholly alcohol-attributable chronic disease] patient was 59% greater for those living in the most disadvantaged neighbourhoods' (p. 4).

Greater rates of alcohol-related harms do not necessarily correspond with greater alcohol consumption. Some of the researchers cited above recognised that, when compared with their low-SES counterparts, high-SES groups have a greater proportion of drinkers, drink more often, and drink more volume overall (Bloomfield et al., 2006; Mäkelä, 1999; Mäkelä & Paljärvi, 2008; Martikainen et al., 2014). These studies also found that the differences between high- and low-SES groups were more marked among women. The English study found that 'drinking every day' increased with the level of highest qualification (MacDonald & Shields, 2004), while the Victorian study (Lloyd et al., 2014) simply noted that 'those with a higher SES are consuming more alcohol'. Complicating this picture somewhat are Livingston's (2013) findings, cited by Lloyd et al. (2014), that drinking more than 20 standard

drinks in a single event on a monthly basis was significantly more likely among both the most disadvantaged and most advantaged neighbourhoods.

A conclusion emerging from these studies is that, as Mäkelä and Paljärvi (2008) put it, the ‘consequences of similar drinking patterns are more severe for those with lower SES’ (p. 728). In the literature reviewed some causal hypotheses are advanced. A few are specific, but most are very general. Of the specific examples, Mäkelä, Keskimäki and Koskinen (2003) tested whether a differential quality of treatment in hospital settings might contribute (at least in Finland) to alcohol-related harm, but ruled out this hypothesis. Mäkelä and Paljärvi (2008) suggested that there could be ‘a bias against recording an alcohol-related code [for cause of death] for individuals of higher SES’ (p. 732) and that higher-SES individuals may ‘be able to choose to drink in safer environments or take a taxi home instead of driving’, but offered no evidence to support either of these hypotheses. Some hypotheses assert a bi-directional causal link between alcoholism and unemployment, with the resulting effect of a greater proportion of morbidity and mortality in lower-SES (i.e. lower-income) groups and provide some evidence to support this. For example Mullahy and Sindelar (1996), cited by McDonald and Shields (2004), found that individuals who had ever met criteria for problem drinking were less likely to be employed full time than individuals with no such history. However, this explanation offers no more than a partial account of the share of morbidity and mortality associated with chronic conditions among older drinkers. Another hypothesis that has been advanced is ‘the unequal distribution of alcohol advertising and/ or bottle shops in more disadvantaged neighbourhoods’, (Lloyd et al., 2014 p. 5 referring to research by Livingston, 2012b). However, this explanation implies that greater availability leads to greater consumption, which in turn generates greater harms; a causal flow that does not fit with the observations that lowest-SES groups tend to drink less. The remaining causal explanations advanced in the literature are very general and deploy notions such as the social determinants of health (Lloyd et al., 2014; Loring, 2014), deprivation, and differentials in social and cultural capital (Mäkelä et al., 2015) or stigma (Room, 2005), without providing any specific data or causal explanations of how those forces materialise the harms observed. The complex interplay of alcohol use, social integration and mortality and morbidity has been explored by Skog

(1996), who called for greater attention to ‘social factors’ within alcohol epidemiology.

There is some recognition that positioning social ‘factors’ as intermediaries does not have sufficient explanatory power, and that a more detailed understanding of the causal mechanisms is required. Mäkelä and Paljärvi (2008) state that ‘future studies are needed to explain how higher socioeconomic groups manage to escape the consequences of drinking that others have to face’, while Lloyd et al. (2014) call for ‘more research that considers these harms within the context of the social determinants of health, and especially in relation to inequity’ (p. 7).

We can observe that even among quantitative researchers there is recognition that other causal models are required. One route out of this impasse is to follow Latour’s injunction to treat social ‘factors’ as ‘a bifurcation, an event, or the origin of a new translation’ (Latour, 2005 p. 128). With this in mind, the next chapter traces the ‘translations’ of drinking events affected by social forces, rather than the simple mediations of social ‘factors’.

## **Conclusion**

In this chapter, I have traced some of the processes of simplification involved in one type of epidemiological enactment of alcohol and its effects. The stabilising of alcohol as ‘causing’ ‘deaths and morbid events’ in preference to being ‘associated with’ or ‘related to’ these outcomes is aided by the constitution of three collateral realities: alcohol is a stable pharmacological agent that acts independently and consistently and produces quantifiable effects; alcohol effects are most visible at the population level and therefore populations rather than individuals are the entity of primary public health concern; and social or other ‘factors’ may amplify or diminish the force of alcohol effects by altering the volume of alcohol consumed but not the causal relationship between alcohol and its effects.

This causal model runs out of explanatory power when confronted with non-linear relationships between populations, alcohol consumption and alcohol harm, as is the case with the differentiation of alcohol effects by socioeconomic group. It is well

established that alcohol-related harm is disproportionately prevalent among low-SES drinkers, but epidemiological investigations have been unable to explain those links causally. I have argued that this inability arises from the prevalence of the consumption-as-harm proposition, which proceeds from the assumption that alcohol acts in stable and quantifiable ways. In this model ‘social factors’ have been associated with increasing or decreasing harms by modulating consumption, but they have not been understood to have transformed alcohol effects in other ways. Nevertheless, taking alcohol consumption as a proxy for harm retains a common-sense status.

What political effects might result from these simplifications? Alcohol—its pharmacology, its effects on bodies, its agency—is prioritised. This, of course, is understandable given that public health relies principally on alcohol availability strategies—that is, regulating the substance through taxation, reducing trading hours or the number of licensed premises, lowering the geographical density of liquor outlets, and so on—as its primary tool. And, as I noted above (citing Mol), public money can only be spent once. But this type of epidemiological research and the public health policy it encourages also continues to materialise alcohol as a powerful (somewhat malign) agent capable of ‘causing’ unwanted outcomes. In this, there are echoes of a long-established way of understanding AOD problems: as arising from the power of the substance to erase reason and rationality, and to produce disinhibition and ‘irresponsible’ conduct on the part of its consumers.

In Law’s terms, this type of alcohol epidemiology makes present and visible the powerful agency of alcohol—alcohol as non-human actant capable of making things happen. But this visibility, this making present, also serves to delete, to render less visible, other aspects of the assemblages in which alcohol acts. For example, the complex mechanisms through which socioeconomic status mediates alcohol effects remain aporias shrouded by nebulous notions of deprivation, stigma and social determinants of health.

In the following chapter, I aim to show how some alcohol effects are co-produced by the (low-socioeconomic) socio-material networks in which drinkers are enmeshed.



## Chapter 6

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# Assembling interrelations between low SES and acute alcohol-related harms

In this chapter I employ the assemblage causal model that I introduced in Chapter 3 to analyse qualitative case studies, and demonstrate some of the causal mechanisms at work in the drinking events of low-SES young adults. The analysis demonstrates that, in the case studies, alcohol-related harms are co-produced by troubled family and ethnic patterns of relations to alcohol and associated memories; victimisation of those defying gender norms in public spaces; insufficient access to housing; and systems of exchange used by drinkers whose orientation to time is unconventional. Framing the causes of harm in this way recognises the complex causality of alcohol-related harms and implicates the social, economic and material networks in which young drinkers are enmeshed.

The methods used to develop this chapter were presented in Chapter 4. To recap, I gathered data during interviews with a convenience sample of heavy sessional drinkers who were aged between 18 and 24 years and who resided in Broadmeadows and nearby suburbs. Participants were recruited during fieldwork at different sites in Broadmeadows. Fieldwork involved regular visits over several months, travelling through the area on foot and attempting to establish relations with locals. I selected the cases discussed here for their reference to harms that were plausibly linked with low SES, or for their contrasts with such cases. My empirical focus is on the drinking event, and I draw on the interview data to detail figurations that moved between the event in focus and the following of actants backwards in time and to different places and contexts.

Duff (2013) has suggested that, in light of theoretical insights emerging from STS, a research question of interest to drug and alcohol researchers is: ‘what kinds of associations, between what kinds of actors, objects, entities, actants and forces, are involved in the production of ... [alcohol-related] problems’ (p. 169). I use this research question to analyse the data presented. The enactment of alcohol-related problems will follow from the definition of harms provided in Chapter 4, that is, harmful events are taken to be those that decrease a subject’s capacity to assert agency, feel and operate in the world.

Despite the differences between the notions of harm I use and those deployed in the epidemiological literature, there are significant overlaps. For example, in literature concerned with alcohol-related mortality and morbidity among low-SES populations, data on hospital attendance and deaths are taken as the outcomes of concern (Herttua et al., 2008; Mäkelä, 1999; Mäkelä et al., 2003; Mäkelä & Paljärvi, 2008; Martikainen et al., 2014). In my case studies, I identified two outcomes that would often be associated with a hospital attendance or a death, and would thus be directly legible to epidemiological studies: a pedestrian being hit by a car and an assault. Other outcomes that I have documented, such as the gatecrashing of a private party leading to police attendance and apprehensions of violence in a public place, would be legible cases in studies assessing associations between SES and ‘alcohol’s harm to others’ and studies using police data (e.g. Laslett et al., 2011).

The cases are presented here within three separate patterns of relations, which can be described as webs of causal connection between alcohol and particular types of actors and actants. Each pattern of relations is prefaced with a review of cognate literature. These bodies of literature are presented here to show how my assemblage analysis departs from previous accounts of the pattern of relations in question.



## **Patterns of Relations**

### ***Family, ethnicity and memory***

This section introduces four cases. The first two trace distinctly different family and ethnic patterns of relations to alcohol, and in their contrasts, suggest how different family and ethnic patterns of relations to alcohol can transform alcohol effects, some of which, in the context of low SES, can be harmful. The second two cases add the agency of memory to family and ethnic patterns of relations to alcohol, and trace the causal flows towards harmful effects.

Family and ethnicity are considered together here because of their thick relations of mutual co-constitution; neither force can be adequately explained without reference to the other. Families, and particularly the effects of parental drinking upon offspring, have long been matters of concern in AOD research. Valverde (1998) documented the late nineteenth- and early twentieth-century popular and scientific concerns with the degenerative and atavistic effects of parental drinking. More recently, the alcohol use of pregnant women has taken on new moral impetus with increasing public health concern about foetal alcohol syndrome and foetal alcohol spectrum disorder (Bell, McNaughton & Salmon, 2009; Lupton, 2012; Salmon, 2010). In contemporary AOD research, families have been enacted variously as sources of norms (Jones & Magee, 2014; Swaim, Beauvais, Walker & Silk-Walker, 2011) vigilance (Hurt, Brody, Murry, Berkel & Chen, 2013) and stressors disposing people to drink (Gutman, Eccles, Peck & Malanchuk, 2011). Participants in quantitative studies are sometimes asked if they have a history of alcoholism in their family and their positive or negative answer is later statistically controlled for or associated with other variables (e.g. Altamirano, Fields, D'Esposito & Boettiger, 2011; Duncan, Gau, Duncan & Strycker, 2011). These studies enact various mediums of transmission for patterns of relations to alcohol between members of families. These might be characterised as genetic, biological, normative, biopolitical or behavioural. In the present analysis, I seek to add ethnic patterns of relations to alcohol to this list.

Anthropology has long understood families and ethnic groups as effects of continuous processes rather than expressions of fixed essences or structures (Candea,

2008; Edwards & Strathern, 2000). These processes enact and delimit family and ethnic groups on multiple scales, such as national or regional heritage, religious, ancestral or language affiliations. Common patterns of relations to alcohol can be one of the processes holding scales of family and ethnic groups together (A. J. Gordon, 1978; Moore, 1990). In the following cases I will show that differing patterns of relations can drive members of families and ethnic groups apart. By strengthening or eroding the bonds that hold groups together, alcohol can co-constitute family and ethnic relations. Similarly, family and ethnic drinking practices can co-constitute the effects of alcohol. Low-SES young adults remain more dependent on their family and ethnic networks for housing, transport and other material supports than their higher-SES counterparts, for whom independent income, housing and transport are more accessible. This, I argue, intensifies the consequences of reproducing or resisting family and ethnic patterns of relations to alcohol. The data from this study suggests that these causal flows can play a role in the production of harmful outcomes in drinking events.

***Reproducing or rejecting ethnic and family patterns of relations to alcohol***

At the time of my interview, Ulla was a 19-year-old second-year university student. She lived with her mother and father and four siblings in the North Park Estate. In addition to her full-time studies, she worked in a bookshop in a nearby suburb. Ulla said that as the oldest sibling she carried a lot of responsibility for her family. Ulla's family moved to Australia when she was five years old to get away from the drinking culture in New Zealand, which, according to Ulla, was much more pervasive than here. In New Zealand, Ulla has had two uncles die from liver disease and two of her dad's brothers are 'getting sick' from alcohol use. 'They used to drink EVERY day', Ulla said: '[it was] dependent drinking'. Deploying a pervasive discourse, Ulla made the point of distinguishing dependent drinking from occasional heavy drinking, with the latter—but not the former—being 'very common' among her family and ethnic group in Australia. Ulla identified as a Polynesian and a Christian, and she regularly attended a Polynesian Church with her family. During the interview she described an event that started with her gathering with three Polynesian church friends at a performance of a New Zealand band in the CBD. They each took turns to visit the bar: 'I went the first time and that's when we had the first round', then others took

turns because they ‘didn’t want to leave’ their space in the audience. After the concert, the group travelled by train to a suburb near Broadmeadows, where a cousin of Ulla’s picked up the group in his car: ‘He hadn’t been drinking. He was working—he had just finished and that’s when he was dropping off people’. The group travelled to join friends and family at another cousin’s house. This cousin was ‘in her mid-twenties, so she has her own apartment’. After drinking alcohol supplied by the host with her family and friends for several hours, Ulla ‘crashed in the living room’. When Ulla woke in the morning, the host had left for work. ‘I phoned my dad to come pick me up’, Ulla said, and she returned home to get ready for work. In addition to this event, Ulla also explained that she had recently drunk alcohol at *siva* (Polynesian dance) events and at a family baby shower, at which alcohol products were given as gifts and then shared around. Ulla’s drinking practices seem consistent with those of her family and her ethnic groups, with whom she is deeply enmeshed. While Ulla’s family group in Australia drink heavily, they are not ‘dependent drinkers’ and as a result they do not understand their drinking as problematic. Ulla is insulated to some degree from acute harms of drinking because she is accommodated and transported by her family during and after drinking events. This is possible because her drinking is consistent with her family’s patterns of relations to alcohol.

Marwan’s drinking occurs in very different circumstances. At the time of our interview at Southmeadows Youth Services Marwan was 20 years old and lived in a suburb in the Broadmeadows area, in a ‘granny flat [self-contained bungalow]’ at the rear of his family house. He was raised by his single mother, along with a sister and two brothers. The family is Lebanese and Muslim. Marwan described his two brothers as particularly religious. They don’t use alcohol, cannabis or tobacco: ‘they’ve got beards and they pray five times a day’. Marwan works occasionally with a cousin’s fencing company, but at the time of the interview, a ‘sore back’ prevented him from working. Marwan said he was good with computers and aspires to work in IT or in an office job. At the time of the interview, Marwan did not have any qualifications or work experience that might be to his advantage in seeking office work, but he was a client at Southmeadows Youth Services. Two scales of Marwan’s identity—family and Islam—forbid alcohol. Marwan told me:

Every time before I drink and stuff, I get really upset, like I argue with myself. Should I do it, should I not do it? Most of the time I usually end up doing it. And I know it's wrong and stuff like that. So I've got a lot of barriers, but I still end up drinking.

Marwan suggests here that he wrestles with shame and the conflicting forces of his peer group's drinking practices and adherence to his family and ethnic identity. He said of one occasion when his family saw him drunk:

Oh, they were really upset and disappointed. My mum usually, like she's a very angry person. She wanted to kick me out and stuff (laughing) ... like they look at me really bad after that. It's like I'm a big, I don't know, like I'm not part of them. That's the way they start looking at me.

Marwan is aware that by failing to adhere to this family, ethnic and religious pattern of relations to alcohol, he jeopardises his legitimacy as a member of these groups. On another occasion he was hit by a car while moving through public space at night while drunk. He explained:

I can't remember how I ended up where I did, but I remember walking down one of the main roads and a cop car just came up next to me. They must have seen obviously how drunk I was, so it was night time as well, so they flashed their lights and I just started running. For NO reason. You know, I was just absolutely drunk. And I crossed the road without looking, a car just hit me. After that, I got up. I kept running, I fell down.

In this event, Marwan was disoriented, alone and fearful of detection, moving through dangerous territory. Despite having his phone with him throughout the event he described, Marwan did not feel he could contact his family for help. In this respect, an assemblage of alcohol, family and ethnicity reduced his capacity to assert agency, feel and operate in the world. Unlike Ulla, whose family members readily

provided accommodation and transport and thereby facilitated her drinking, it was not possible for Marwan to receive such support, and this was one of the forces that lead to the acute harm of being hit by a car. This is an example of families transforming alcohol effects, by insulating, or failing to insulate, young drinkers from harms during drinking events, depending on their patterns of relations to alcohol. It is also evidence that, as a university student with part-time employment and good relations with her family, Ulla has markedly more resources to call upon during drinking events than Marwan.

### *Adding the agency of memories*

Families and ethnic groups can alter the effects of drinking events in other ways too. The following two cases demonstrate how individual and collective memories can join with family and ethnic patterns of relations of alcohol to produce harmful effects. Several bodies of research literature consider alcohol and memory, including studies that enact alcohol as a non-medical palliative to counter past traumas (e.g. Elwyn, 2013; Najavits, Weiss & Shaw, 1997), and studies of blackouts (e.g. White, Signer, Kraus & Swartzwelder, 2004) and Korsakoff syndrome (e.g. Kopelman, Thomson, Guerrini & Marshall, 2009). One corpus enacts memory as a neuropsychological performance of the brain by comparing different categories of drinkers' scores in various symbolic memory-games (Day, Celio, Lisman, Johansen & Spear, 2013; Grattan-Miscio & Vogel-Sprott 2005; Parada et al., 2012; Schweizer & Vogel-Sprott, 2008). Behaviourist studies have documented memories of previous drinking events acting upon the propensity to use alcohol (Stacy, 1997; Wiers, Woerden, Smulders & Jong, 2002). None of these studies considers the intersections of alcohol and intrusive cognition of memories, so they cannot account for the agency of memories in the cases considered here.

Kylie and Mike were both 21 years old and living together as a couple in a rental property near Dallas Brooks Mall when interviewed. Both are of 'Aussie' appearance; there was an Australian flag hung in their living room window, facing the street. At the time of the interview, Kylie and Mike were still setting up their home after recently moving in. Kylie was unemployed and Mike said that he worked a few shifts a week at a local primary school. When I asked Kylie and Mike to tell

me about a recent drinking session, they told me about an event around 10 months prior to the interview, a celebration for Kylie's 21<sup>st</sup> birthday. The couple shared a bottle of Jim Beam whisky, which they tend to 'stick to' because they don't 'like the taste of anything else.' They estimated that they drank between a quarter and one half of the bottle together, 'a couple of glasses' each. '[T]hat's it (laugh) that's all you need', said Mike. 'You don't need more than a couple .... Once you're over that couple, you've just gone too far with it, I reckon', said Kylie. Kylie is wary of alcohol for several reasons. She explained:

My aunty Tracey ... she's been an alcoholic most of her life because her brother took her daughter away from her and took custody of her daughter without her permission. She didn't even know it was happening and stuff like that! But I've had practically everyone in my family in jail, pretty much. Even my step-dad, he's been in and out of jail all his life. Basically, everyone around me—like I've had aunts and uncles who've become alcoholics—they've become addicted to certain drugs and they're just unbearable. I can't stand to be around some of my family ... I tend to stay away from that part of my family.

Kylie suggests here that she does not wish to reproduce the pattern of relations to alcohol common in her family, and as a result, she is an infrequent and moderate drinker. Kylie's circumstances are similar to those of Marwan's insofar as they have both become more distant from family as a result of not reproducing their patterns of relations to alcohol. Kylie is also wary of alcohol because of the association between unregulated emotional behaviour and alcohol intoxication. Kylie told me:

Like I've had friends who get drunk and it's "errrrr" (high pitched noise). They just cry to you the whole time that they're drunk ... I reckon it's a build-up of all their emotions and then once they're drunk—because once you get drunk, you tend to talk a lot and you tend to get everything out in the open, once you've drunk a lot and whatnot. 'Cause I used to do that myself. Once they get to the point of drunk, they start crying and they want to bring out all their emotions

and lay it all on you. You'd be like, "Sorry it's too much to lay on me at once", you know.

This sense of drinking events evoking 'too much' emotion suggests that alcohol can act as a medium through which memories become manifest, or perhaps as an inhibitor to the self-control necessary to manage the regular intrusive experience of 'all their emotions'. Kylie's description of her family circumstances and history suggest that unpleasant memories and reasons for thinking about life's difficulties abound in her world.

Deborah and Shari made a similar connection between alcohol and intrusive emotions. Deborah was 18 years old at the time I interviewed her with her older sister, Shari, aged 20. Deborah and Shari lived with six other people from three family groups in a house in the North Park Estate. All identified as Aboriginal, all were under 25 and unemployed and all but two were homeless according to the current definition used by the government statistician (Australian Bureau of Statistics, 2012). Two of the family groupings represented at the house were based in a Victorian regional town, where Deborah and Shari spent their early childhood. Neighbours said that the people in the household were 'big drinkers'. During weekdays, members of the group usually ventured out together to attend appointments at the welfare office or spend time at the shopping centre. Deborah and Shari are descendants of Indian, Lebanese, Australian Anglo-Saxon and Yorta Yorta (an Australian first nation) families. The Aboriginal lineage is from their maternal grandmother, who played a significant maternal role for them. Deborah and Shari identify as having kinship connection to a mission (a clergy-managed colonial reserve in which Aborigines were concentrated and controlled) in Victoria where their 'grandma' was raised after being removed from her mother. During the interview they told me that: 'Aboriginals eat lemon and vinegar [as a hangover cure]'; '[our] family, they could never drink without fighting'; 'grandma was taken away from her mum through drinking'; and 'on this mission [where our family are from], if you're young and you drink and you walk in the street, apparently the [spirits of deceased] drunk ancestors, the ones that were really drunk, come and scare you'. With these comments, Deborah and Shari refer to patterns of relations to

alcohol that relate to different scales of their ethnic and family identity. They indicate that some of these patterns of relations include violence and the separation of families. During the interview, Deborah and Shari indicated that they were ambivalent about heavy drinking but were nevertheless occasional heavy drinkers. Deborah and Shari remain enmeshed with their family and Aboriginal kinship group and, it seems, reproduce some of their patterns of relations to alcohol. I asked about their most recent drinking session. 'Last Saturday' was the answer, when 'at least five of us' were drinking at a house in an outer western Melbourne suburb. Although the group consumed 'two bottles of Jim Beam' mixed with soft drink, Deborah only drank 'one glass' because she was 'upset'. Sometimes when Deborah drinks, it gets her 'all emotional'.

Yeah it does, kind of get me emotional. Things that have happened ... It still running in your head so, it brings it up, or someone around you has to mention something that has something to do with the life story ... And 'cause last time I drank I got a bit violent [she assaulted a woman, for which she faced charges] so, I don't really like drinking. I love drinking but, it gets to a certain point that I know that I have to stop. Like, I'll drink a certain amount then, you know, if I don't feel right then I will stop.

Deborah, like Kylie, suggests that intrusive memories and feelings manifest during drinking sessions. These intrusive memories can lead to violence, which has caused trouble for Deborah in the past. Deborah had been exposed to heavy drinking and violence among her family from a young age.

I used to have to sit around and watch my family drink. Sometimes it would get very, very scary because ... they were very dangerous people.

Deborah and Kylie and their respective families have experienced traumatic alcohol-related events, and both young women described becoming upset and emotional while drinking. Given the analytic task at hand, this description could be refigured to



say that memories exert agency in Deborah and Kylie's drinking events, and that this assemblage of forces is harmful insofar as it reduces their capacity to exert agency, feel and operate in the world. For Kylie and Deborah, drinking events are dangerous. They are also webs of connection to their kinship groups and establishing greater distance from drinking events results in greater distance from their kin.

My analysis of the agency of memory, family and ethnicity in drinking events shows that family and ethnic groups and their patterns of relations to alcohol can be among the entities at work in drinking events that engender harm among low-SES young adults.

### ***Drinking settings***

This section introduces a further three cases. Each contrasts the effects of alcohol assemblages located in particular spaces and times. The data are used to argue that, for the participants, some drinking settings co-produced harms, while others were protective.

The role of settings in drinking events is considered in some recent AOD literature. Results from a survey of 16–24-year-old 'risky drinkers' in Victoria (Dietze, Livingston, Callinan, & Room, 2014), which was a component of the wider ARC-funded study to which my project contributes, suggested that 62% of heavy drinking sessions start in private homes, and that about half of these moved on to a licensed venue afterwards. MacLean, Ferris and Livingston (2013) found that young adult drinkers in Melbourne's outer-suburban 'growth areas' were significantly more likely to drink at 'private parties' than their inner-urban counterparts, who drank significantly more frequently at licensed venues (p. 13). Grace et al. (2009) discussed the practical affordances of drinking in private settings among their sample of young adult drinkers in Perth. These include: 'a way of saving money, of ensuring an adequate level of intoxication prior to going out, of making plans regarding transport and creating the right mood amongst participants' (p. 25). MacLean and Callinan's (2013) quantitative and qualitative study of the phenomenon of 'pre-drinks' among young adult drinkers in Victoria focused primarily on the link between pre-drinking and the (increased) volume of alcohol consumed, though the private settings are

noted as 'fun' and 'social'. Holloway, Valentine and Jayne (2009) argued that a 'dearth of research on private drinking environments' (p. 823) arises from a research agenda skewed towards masculine drinking in public spaces. They produced data from a UK sample showing that 'significantly greater numbers of women than men drink regularly in ... friends' and family homes' (p. 824), and argued for research to consider a more diverse range of drinking environments in order to more fully explore 'the gendered geographies of alcohol consumption' (p. 824). Pennay (2012) discussed private spaces as a site for ecstasy use, primarily in terms of the performance of 'grotesque bodies', which do not 'align with public health constructions of good, ordered, healthy bodies' (p. 411). Pennay contrasted the norms applying to drug use in different spaces for her ethnographic sample, and finds that private spaces enable a fuller expression of ecstasy effects, effects that would be 'wasted' in other contexts, such as nightclubs, where the behavioural norms and staff surveillance would require users to 'control' themselves by 'acting ordered' (p. 417). Settings have long been recognised as co-constituting the effects of AOD use, perhaps most influentially in Zinberg's (1984) *Drug, set and setting* hypothesis. More recently, settings have been re-theorised as time-space assemblages that, in addition to co-producing drug effects, co-produce substance-using subjects (Fraser, 2006). It is through this latter enactment of settings that data from this study will be analysed.

Onur is 23 years old and of Turkish heritage. He has lived in the Broadmeadows area his whole life. He left school in year 10 after his educators decided that he could not progress to Year 11 without repeating a year. He looked for work, but without regular commitments, he 'started hanging around the wrong crowd' and 'got into the drugs and alcohol'. This continued until he ceased regular and heavy drug and alcohol use at about age 21. Although Onur had worked in the construction industry, at the time of interview he had been attending a full-time work-for-welfare program at the North Park Estate Community Centre for three months. He lived with his girlfriend and her family; the couple had a year-old daughter and another baby coming.

Onur described a heavy drinking session that had occurred around two years prior to the interview. He joined some friends in a park and the group went to buy drinks, purchased individually. The group returned to the park and drank heavily. As drinks were consumed and some drinkers ran out, others shared theirs: 'there was always a back-up for someone'. Some members of the group had heard about a 'house party' nearby, and Onur felt conspicuous drinking in public. Although none of the group had been invited, they decided to attend and walked to the house. Although they were quite drunk, the group had hoped their attendance would be inconspicuous:

[we] weren't trying to do no trouble ... a few people were walking in just ... We didn't like crash it like that bad but we were just trying to get in, you know like that, we send ourselves to the party.

Their entry was not inconspicuous however; 'everyone's like, "who are these guys?"' '[T]he parents came down and telling us to go away'. The group did not leave and the parents called the police. When they heard that the police were coming, the group left, but by this time, the group had made an impact on the party: 'we were just drunk and spoiled it for everyone'. With the benefit of hindsight, and as a 'better person', Onur could empathise with the position of the party hosts and expressed some regrets about this incident:

you just see what it does to that, like, it's no good ... it's just the truth I guess, but, well once you get older you see about things. And I imagine now it's happening to me ... Yeah, that's just very rude. Because I'm a better person I guess too.

Given Onur's regret, I suggest that the gatecrashing incident was harmful to him, his friends and those at the party. The event would certainly have been less distressing and for all concerned had Onur and his friends had access to a different setting where their drinking and other practices would not have contravened the dominant normative standards to the same extent. Field observations of licensed premises undertaken for this study established that the foci of licensed venues in Broadmeadows and surrounding areas included poker machines, sports betting and

bistro-style dining. Heavy sessional drinking was scarcely evident, and young adults' heavy sessional drinking was not observed at all. Another observation is that drinking by young people in public places, including parks and Dallas Brooks Mall, is transgressive in Broadmeadows, and that the exclusion of these practices had harmful consequences in this instance.

We might reflect that, had Onur and his friends had access to an appropriate private drinking setting, they may have avoided the harmful outcome. Perhaps his Turkish family's pattern of relations to alcohol played a role here. We might also reflect upon the role of housing within Ulla and Marwan's drinking events. In Marwan's case, his unemployment and associated housing circumstances meant that he remained deeply interdependent with his family, despite the tensions this involved. If Marwan was independently housed and employed, his failure to reproduce his family and ethnic group's pattern of relations to alcohol is unlikely to have been so consequential for him. In Ulla's case, her cousin's employment enabled her to rent a unit which provided a safe location for drinking and sleeping afterwards. Private drinking settings then, can exert a powerful agency in drinking events.

During the interviews, the 'free house' appeared in seven of 14 drinking events studied. Participant accounts suggested that a free house is a private drinking setting where the norms and practices of the peer group can go unchallenged and without surveillance. One participant described the advantages of a free house when she said 'so we can have free range, so we don't have anyone staring back at us, and we can kind of let go and don't have to worry about it all and stuff like that.' Free houses can be the sole location of an event, the location of 'pre-drinks' or the group destination following attendance at a licensed premises. Free house practices involve drinking, listening to music, dancing, sitting on the couch and talking, 'making out', just 'hanging out', playing party games, smoking cigarettes and cannabis, and 'generally making a lot of noise'. Free houses provide an informal, relaxed and playful environment where young drinkers perform their affinities and take pleasure in combining sociality with intoxication. They can co-produce intimacy, encounters with new people and controversy. They also allow young drinkers to perform a 'drunken party crash', where drinkers go to sleep at the party location, usually on

improvised bedding. Some drunken party crashes were followed by further sociality in the morning. One participant said of a particular event: 'I was feeling sober enough so I was making breakfast for everybody that needed to eat.'

The free house 'drunken party crash' increases the capacity for young adult drinkers to assert agency, feel and operate in the world in four respects. First, it allows young drinkers to sober up before negotiating transport home and the people they encounter there. Second, it allows them to journey home during the day when transport is more available. Third, it can allow the peer group to spend the morning together, as when a participant made breakfast for her friends. Fourth it negates the risks associated with moving around the Broadmeadows area at night.

These risks were particularly acute for Robert, who was 19 years old and had lived in the Broadmeadows area all his life. At the time of interview he worked in retail sales in a city department store and did other occasional work in the fashion industry. After finishing secondary school, Robert completed a one-year course in fashion design, but was not studying at the time of the interview. He aspired to a career in politics, fashion or youth work. Robert was a major contributor to the same-sex-attracted support group at the North Park Estate Community Centre and characterised himself as very 'out of his shell'. He was the only openly gay male at his high school, where even the principal was very 'anti-gay' and he suffered sustained victimisation. 'It was very painful, so it was really hard', he said. Robert felt that the Broadmeadows area was very hostile for him:

once you walk out the door there's ridicule, [people] shout at you instantly, crossing the crossing people yell out things. You walk to the station you get eyed nonstop, thinking someone's going to hit you or someone's going to think that you're faggy or freaky or whatever just because I'm skinny and tall and dressed nice, and people just make assumptions.

Robert very rarely walks through public space in Broadmeadows and avoids using public transport at night. In contrast, during a free house party Robert attended, he

described playfulness: ‘I remember fighting over Doritos [corn chips] because someone stole a bag of Doritos and I kind of like chased someone around the table for a pack of Doritos’; intimacy: ‘just keeping to ourselves and having our own conversation because everyone was either coupled off talking or couples were talking’; and controversy: Robert was involved in a conversation about a friend with three people, two of whom were ‘bitching non-stop’, while the other person ‘was just sitting there and not saying anything’. The experience of being ‘faggy or freaky’ or worried about abuse or physical violence was entirely absent from this setting, and in this sense, the time-space assemblage of the free house co-produced Robert’s subjectivity in ways that weren’t harmful or threatening to him.

Like Robert, Courtney was acutely aware of the risks of moving around Broadmeadows at night. Courtney, an ‘Aussie’ in her early 20s, had lived in the Broadmeadows area most of her life. At the time of interview she lived with her father. Courtney did not work or have many commitments: ‘I play PlayStation and have appointments and stuff ... that’s what keeps me busy’, she said. Courtney finished school during Year 10, after struggling to keep up: ‘I had integration aides [classroom assistants] all through High School and stuff’. Courtney identified as suffering from anxiety and an autism-spectrum disorder. After leaving high school Courtney tried to complete her secondary education through a local college but ‘it didn’t work out too good’, so she moved to a music program in the same institution, which she pursued to completion. Courtney loves music and has a punk/goth/metal subcultural style of dress and comportment. Courtney started going to clubs catering to this scene with her older sister and, in these settings, connected with her current group of friends. Courtney described feeling ‘comfortable and safe’ when with this group of people, but not in public spaces around Broadmeadows. The interview transcript records the following exchange:

C: If you dress like me around Broadmeadows, you always get like those idiot people who think they’re top ... yeah ... ah, you know.

A: So you kind of feel that Broadmeadows is a bit hostile to subcultures?

C: Yeah yeah. I think that they are—especially like the friggen Lebos [Lebanese] at the train station ... Arggh!

A: At Broadie Station? And what do they say or what do they do that makes you uncomfortable?

C: Oh they just make stupid noises and stuff ... but I think that it's like—that's got to do with alcohol as well. 'Cos like, people that drink make stupid ... they think they're like top of the world and they just do stuff without thinking, so ...

These encounters with young men from a Lebanese background made Courtney feel intimidated on and around public transport. Courtney was most often too anxious to go out and had not had a social drinking event in the six months prior to the interview.

These data suggest that participants' capacity to express agency, feel and operate in the world was transformed by drinking settings in powerful ways. Onur's subjectivity as a gatecrasher was co-produced by the private residence that he and his friends attended during their drinking session. This exposed him to potentially harmful contact with police and rendered his youthful self as shameful in the eyes of the 'better' self that he performed during the interview. Had he and his friends had access to a free house during their drinking event they might have performed their affinities and enjoyed sociality and intoxication without contravening the normative standards prevalent within that time-space assemblage, and thus avoided the associated negative consequences. Further, they might have enjoyed some of the other benefits of free houses listed above. Concerns have been raised over the greater volume of alcohol consumed in private residences (Dietze et al., 2014), but these concerns arise from the proposition that intense alcohol consumption can be taken as a proxy for harm. Analysis of data in this study suggest that, among low-SES young adults with very limited access to licensed or other appropriate drinking settings, drinking in private spaces can be enacted as an appropriate harm reduction strategy rather than as a risk factor. Conversely, low-SES young drinkers' limited access to housing may be associated with the greater incidence of harms arising from their drinking.

Within the free house time–space assemblages inhabited by Robert and Courtney’s groups of friends, they adopted subcultural norms and aesthetics and felt comfortable and safe, despite the presence of alcohol-intoxicated bodies. Within the night-time public spaces in Broadmeadows, Robert and Courtney’s subjectivities emerged as easily identified members of transgressive subcultural groups, leaving them exposed to abuse and violence. According to Lindsay (2006) and Pyke (1996), lower-SES environments tend to have more rigid gender norms, and we might understand the homophobia experienced by Robert and the verbal abuse of Courtney as associated with this phenomenon. Alcohol use has been attributed with ‘increasing the risk of victimization by violence’ (Laslett et al., 2011 p. 61), but analyses of these data suggest that public time–space assemblages in Broadmeadows can also co-produce such harms.

### ***Systems of exchange***

Alcohol is often purchased and consumed through a system of resource sharing between two or more people. There is evidence to suggest that this is a widespread practice, with a recent representative survey of young ‘risky’ drinkers in Victoria suggesting that, on a typical heavy drinking occasion, drinkers spent a median of \$23 on drinks for others, and consumed \$37 worth of drinks purchased by others (Dietze et al., 2014). In this section I consider these interactions and refer to them as ‘systems of exchange’. I introduce two further case studies, and extend the analyses of case studies from previous sections. I argue that in some of these data, systems of exchange are used by drinkers whose orientation to time is unconventional, due to their economically and institutionally dis-integrated circumstances, and serve to reinforce participants’ marginality by draining their resources and perpetuating their non-conventional temporality. I also argue that these systems of exchange can be associated with events of acute alcohol-related harms.

Apart from the small field of studies which consider ‘shouting’<sup>10</sup> practices (e.g. Barbara et al., 1978; Kapferer, 1988; Moore, 1990), systems of exchange have not

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<sup>10</sup> Purchasing alcohol in rounds



received much attention in the alcohol literature. Systems of exchange are sometimes documented in anthropological literature (e.g. Hannerz, 1969 p. 56; Sansom, 1980 p. 51) but alcohol use and its effects are not the primary concerns of these texts. Social constructionist alcohol studies have explored a range of symbolic qualities of alcohol and drinking, as discussed in the literature review chapter, but they have not often included systems of exchange as a matter of concern. Dorn's (1983) ethnographic study of working-class London youths of school-leaving age identified ways in which position in the labour market influences shared purchasing arrangements. He observed that youths of structurally similar labour market prospects, but temporarily different means, managed to obscure the differences in their spending power through careful choreography of shouting practices, and in this way reconcile 'the ideal of equal participation in the round, and the reality of insufficient funds' (p. 195). Youths in structurally different economic positions did not participate in the same round-buying groups, compounding delineations of unequal status and socioeconomic opportunity.

Mauss (1969) articulated the centrality of object exchange in forming and maintaining social relations through his analysis of *kula* and *potlatch* practices among Melanesians in the Trobriand Islands and indigenous North Americans. The persistence of these notions in sociology and anthropology is such that they 'could be said to have achieved the status of paradigm' (Johnson, 2008 p. 307). Systems of exchange can infuse alcohol products with the symbolic properties of a gift, but the particular role of alcohol in the gift economies of people in developed countries, and the agency of those economies in mediating alcohol effects, is largely absent from scholarly literature. In the broader drug literature, Dwyer's (2009) study of a heroin marketplace describes how heroin is exchanged in multiple ways, for multiple purposes and according to multiple and fluid classifications of social relationships. She used these ethnographic observations to challenge the representations of subjects in the marketplace as *homo economicus*, 'the individual, autonomous, rational', risk-averse maximiser of utility.

The interpersonal functions of exchanging alcohol can be identified in some of the events already described. As drinkers in Onur's group ran out of alcohol during their

session in the park, 'there was always a back-up for someone'. Use of the term 'back-up' here hints that masculine expressions of honour and solidarity were exchanged along with the alcohol. When Ulla and her church friends went to a music concert in the city, they each took turns to visit the bar and bring back a round of drinks. After the concert, the group travelled to Ulla's cousin's home together, and there Ulla introduced them to other friends and family members. These accounts feature a collective affinity practised in and reproduced through the shared purchase of alcohol. Robert's drinking event, in which drinkers kept their alcohol to themselves and the social bonds were much looser (and more conflicted), offers a counterfactual case for this proposition. The much-noted socially integrative functions of alcohol are generally understood as an affordance of the pharmacological substance, or of the social context of alcohol consumption. The data in this study, however, suggest that alcohol's putative effect of strengthening bonds between friends may also be attributed to shared purchasing practices.

Another theme worthy of exploration in the context of systems of exchange is the temporal horizon of drinking events. Temporality is a much-theorised and debated phenomenon in anthropology and sociology (Munn, 1992) and its relations to drug effects have been explored in AOD literature (e.g. Fraser, 2006; Keane, 2002). A common theme in this literature is the multiplicity of time scales and horizons in addition to those anchored by clocks and calendars. In the context of the heavy drinking session, one plane of periodicity is marked by the exhaustion of alcohol supplies. In other words, the time-space assemblage of the drinking session is bounded by the number of drinks at hand. One effect of some of the systems of exchange identifiable in the events studied is that which increases the average quantity of alcohol available to each drinker, increasing the intensity of consumption and expanding the temporal range of the drinking session. Such a scenario was described by Onur in the *Drinking settings* section above.

A further example of a system of exchange with temporal effects can be found in a drinking event Ben attended. Ben started skipping school in year 10 and 'fell in with the wrong crowd'. At the time of the interview, when in his early 20s, he lived with his parents, was looking for work and received unemployment benefits. He did not

have a car and had been attending a full-time work-for-social-security program for seven months. His friends were mostly people who shared his drinking, marijuana- and methamphetamine-smoking practices. He gathered with these friends at least once each week, mostly at someone's house but sometimes at a club in the city.

His most recent 'big session' was 'last weekend', at a mate's house for his birthday. He drank nearly a whole bottle of vodka unmixed and 12 'beers' in a six to seven hour session. He also smoked methamphetamine and marijuana. At this event, Ben said he 'chipped in a bit of money for the beer'. Shared purchase of alcohol is part of Ben's drinking practice. He said 'I get paid this week, I'll be sharing with James and I know if James gets paid next week he'll be doing the same.' At about 1am, the party wound up and Ben did not attempt the 10-minute walk home: 'I ended up sleeping at my mate's house because I was too drunk to go home'. We might speculate that the money Ben 'chipped in' for the beer was not commensurate with the value of AOD he consumed at the event, and to that extent, the event was more extended and involved more intense consumption than if Ben and his friend James had consumed only what they had brought personally. The mechanics of exchange between Ben and his friend James seem to suggest that both frequently spend all their available money on alcohol and other drugs for a night out. When James shares with Ben for an event, Ben consumes more than he otherwise would, and obliges himself to fund a similar event on a subsequent occasion. This system of exchange acts to prolong the drinking sessions and command a greater share of each party's financial resources.

Another feature of the system is that its imbalance or exhaustion can cause conflict. Ben described the scenario:

When I haven't got money to get something I'm caught up in it and he's [James's] got nothing to get something, you know, end up having an argument with my parents to get some money.

During the interview it emerged that conflict with his parents was a significant problem in Ben's life. Ben referred to some of his life 'problems': his parents' desire

for him to get a job, his arguments with them about money, his limited financial means and his need to buy alcohol and other drugs. Ben described why he likes drinking: 'it's the freedom you know...there's no worry about the problems in my life.'

During the interview, Ben told the story of another occasion:

At one stage I just had a bit too much to drink and just ended up fighting with my mate and ended up bottling him, breaking the bottle on him. We went to the hospital, got about five, six stitches. Yeah it's shit. I probably wouldn't have broken the bottle, if I wasn't that drunk. That kind of made me react more, you know ... At the time, he was really cut with me ... And then I seen him the next day and I told him I was too drunk so in his mind that made me less to blame.

Ben attributes the escalation of violence to his drunken state, which serves to diffuse his guilt and minimise the injury to his friendship. I asked Ben about his current relationship with this friend. 'Yeah, still see him', he answered. 'We talk about it, have a laugh. He keeps saying, "I'll get you back one day when I'm like that".' Ben told me that there had been other occasions when fights with 'mates' had occurred during drinking events. I asked if it ever resulted in the end of those friendships. 'Yeah, no breaking up', he said. It seems that, when intoxicated, trouble between friends can be attributed to drunkenness, and that these attributions can serve to preserve friendships. I speculate that the system of exchanging AOD served to strengthen the ties of friendship, making them strong enough to endure events of violent conflict. In light of the durability of their friendships and their practice of exchanging AOD, Mauss' 'paradigm' of gift giving and social relations seems to hold for Ben and his friends. With this observation in place, I argue that a system of exchange that provides more alcohol than otherwise available extends the temporal range of drinking events, and is implicated in episodes of conflict and violence, also serves to hold in place the interpersonal relations in which these dynamics occur. In this respect, I argue that a system of exchanging AOD between institutionally and economically dis-integrated friends has a causal relationship with events of alcohol-related harm.

Fadi was another young adult heavy sessional drinker who was enmeshed within a system of exchange. Fadi was 24 and lived in a shed in the backyard of his family property in Broadmeadows. His mother and brothers lived in the adjoining house. His family was from Lebanon and of Muslim faith, and his group of friends were from Muslim and non-Muslim backgrounds. Fadi had not been drinking for a couple of weeks prior to the interview as it was during the month of Ramadan. He had, however, continued using marijuana because he was 'addicted'. He had no employment history and had a history of heavy use of methamphetamine, marijuana and alcohol.

Fadi associated his AOD use with periodic depression, boredom and fighting with his girlfriend. 'When you're depressed you've got to drink or do drugs to have fun', he said. Fadi also described himself as having a 'gambling problem', and regularly visited poker machine venues. It was not unusual for him to 'blow' \$500 on alcohol and poker machines in a night out. This figure included Fadi 'shouting' friends who did not have the means to participate otherwise. Because marijuana and alcohol use were common practice among Fadi's group of friends, it was normal for them to share their resources, particularly in relation to marijuana and alcohol. Fadi said:

Say if I don't have any money, I'll go around to my friends' and we'll all have a smoke [or a drink]. Then the next day, my friend might not have any money. We all share and practically take care of each other.

Here Fadi described a system of exchange which was much like Ben's insofar as it was an expression of interpersonal connection (or in Fadi's terms, 'care'), and an enabler of more regular and more prolonged AOD use.

Another point of similarity between Ben and Fadi's circumstances is their conflict with parents. Earlier in his adulthood, Fadi moved out of his family home because 'I couldn't let 'em see what I looked like [when AOD-affected] ... I had to live by myself. I couldn't live life as normal'. Fadi funded his independent living by dealing marijuana and other drugs. This endeavour led to a few months in jail, followed by two weeks of community work, eight months of parole and attendance at court-

mandated drug counselling. Fadi's involvement with systems of exchanging AOD had escalated to the point where it had become integrated with his means of subsistence.

In Sansom's (1980) ethnographic study of Aborigines in a Darwin town camp, newcomers arrive in the town camp flush with funds and make disproportionate contributions to collective alcohol supplies. As their funds dwindle, they recoup their investment by consuming drinks bought by others (p. 51). This system acts to extend the inclusion of those without funds, to prolong and intensify drinking sessions, and to command a greater share of drinkers' financial resources. This pattern of 'boom and bust' is common to other low-status and marginalised cultural groups elsewhere in the world. As Van Doorn (2010 p. 228) noted, in his series of essays on Amsterdam and its inhabitants, Mak (1992) offered an excellent description of this dynamic:

In a world that haggles all day long about coins and the occasional bill, a benefit grant of one thousand to fifteen hundred guilders is an amount far beyond the usual scope. This irregularity in existence is therefore removed in no time. In the pubs and bars in the centre all the blokes play at being the mayor and in May it's a double party because then you get holiday benefits as well. After approximately four days everyone is back to their formerly level: that of dimes, 50 cents and the occasional tenner. (p. 108)

While these practices certainly limit future opportunities for welfare recipients, Van Doorn (2010) contextualised them within a broader restructuring of time and space that is necessary and adaptive for people who spend time 'on streets' and whose bonds to social institutions are 'looser' (p. 223). For those without regular institutional commitments, clock and calendar time have less meaning and perceptions of time move away from 'linear' and towards 'cyclic' models, where 'time is a less demarcated, more diffuse concept', and the:

focus is more on the "here and now" than on the future. There is less planning, less goal orientation, a less marked hierarchy of tasks that have to be performed within a certain span of time. (p. 223)

Van Doorn argued that this temporal reorientation assists her participants to cope with the realities of living on the streets, but recognised that it also makes their transition out of homelessness more difficult. The system of exchange described by Sansom (1980) and the temporal orientation described by Van Doorn (2010) have a clear resonance with one another. Indeed they arguably perpetuate one another: participating in extended, financially ruinous sessions of drinking disrupts connections with the world of conventional linear time, while a “here and now” orientation can make a collective drinking session more appealing, and lead to deeper bonds with others whose temporal and institutional orientations are similar.

Such entanglements are evident in the figurations of Ben and Fadi. Both Ben and Fadi participate in systems of exchange that act to prolong sessions of drinking and other drug use and command a large share of their financial resources. While Ben and Fadi do not live on ‘the streets’ as do Van Doorn’s participants, conflict at home (with their parents) is a common theme, and each regularly spends time ‘hanging out’ with their friends. With the exception of Ben’s engagement in a work-for-welfare scheme, both young men were without the institutional engagements and responsibilities usually carried by working adults.

Given these circumstances, I argue that Ben and Fadi are somewhat oriented to a ‘cyclic’ model of time which acts to reproduce, and is reproduced by, the systems of exchange in which they are enmeshed. The temporal orientation and the system of exchange act together to mediate alcohol effects. They deepen interdependencies between marginalised friends, deplete finances, increase the clock-time spent drinking and consuming other drugs, decrease the time available to pursue more conventional goals and heighten conflict with family members. In all these respects, these alcohol effects act to compound Ben and Fadi’s institutional and economic marginalisation.

To render systems of exchange in terms of their mediation of alcohol problems, I assert that among drinkers with a non-conventional orientation to time, they can be dis-integrative when they perpetuate non-conventional temporality, decrease the time

available to pursue more conventional goals and trigger conflict with family members.

Contemporary public health campaigns have encouraged drinkers to avoid ‘shouting’ (Australian Drug Foundation, 2015; Australian National Preventative Health Agency, 2012; Better Health Channel, 2012). Recent research has drawn attention to the socially integrative affordances of shared alcohol purchases (Murphy, Hart & Moore, 2016), and critiqued public health campaigns for neglecting this aspect. My analyses in this section show, however, that the social bonds afforded by systems of exchange come at the cost of young drinkers’ ability to feel, act and operate in the world in other ways.

## **Conclusion**

In this chapter I presented qualitative data concerning the heavy sessional drinking of young adults in Broadmeadows. I investigated some of the associations between actors, objects, entities, actants and forces involved in the production of acute alcohol-related harms in the drinking events of young adults living in or around Broadmeadows. I introduced cases of a pedestrian being hit by a car, two assaults, a gatecrashed party with police attendance, apprehension of violence in a public place, and deepening institutional and economic dis-integration. In the analysis of case studies, I demonstrated causal flows between these harms and ethnic patterns of relations to alcohol and associated memories; victimisation of those defying gender norms in public spaces; insufficient access to housing; and systems of exchanging alcohol in the context of non-normative temporality.

I also showed that socioeconomic dynamics were at work in shaping drinking events. These dynamics shaped the drinking choices of young adults, and the emergent subjectivities of those who drank heavily. Some young adults carried memories of traumatic alcohol-related events and understood drinking events to be dangerous. Their drinking practices could be volatile. Young adults from Muslim backgrounds sometimes went out to drink and socialise with friends, but did so furtively, traversing spaces where they were transgressing norms, and often without the safe haven of a private drinking setting, or the backup of family supports. Having their



drinking noticed by members of family and ethnic groups sometimes damaged kinship relations. These are the socio-material networks in which young drinkers are enmeshed, and they are the settings that co-produced alcohol-related harms in the case studies presented.

What, it is reasonable to ask, is the significance of these insights beyond the microsocial worlds in which the observations took place? Although it would take quantitative research to establish it to the satisfaction of mainstream sociology, I argue that many of the patterns of relations between alcohol and socio-material networks identified here exist at scale. For example, the trauma of family separation and its interrelations with heavy alcohol use is a common occurrence among Australian Aborigines and other marginalised populations who have been subject to the coercive powers of the state (Human Rights and Equal Opportunity Commission, 1997). Intergenerational conflict over the maintenance of traditional, country of origin norms and practices (e.g. abstinence), or adoption of the norms and practices in the destination country (e.g. heavy sessional drinking) is a recurrent theme among migrant communities (Kayhan, 2008; Renzaho, Green, Mellor & Swinburn, 2011; D. Rosenthal, 1996; D. Rosenthal, Demetriou & Efklides, 1989). A paucity of housing resources (specifically, insecure tenure, poor physical conditions and overcrowding), and therefore of suitable private drinking settings, is more common in socioeconomically disadvantaged areas (Dockery, Ong, Colquhoun, Li & Kendall, 2013; Pawson & Herath, 2015). The enforcement of gender norms through the persecution of those who transgress them, particularly during drinking events and in night-time settings, is more vigorous in low-SES sites, where lower-status men compensate for their 'subordinate order-taking position in relation to higher status males' with 'exaggerated masculinity and misogyny' (Pyke, 1996 p. 531). Practices of 'shouting' and systems of exchanging alcohol as gifts are widely practised, and tend to bind groups of drinkers together, but they can also be powerful delineators of social hierarchies, and perpetuate unequal economic and social opportunities (Dorn, 1983). While, within the STS causal framework, no claims can be made about the stability of the causal chains between these dynamics and alcohol-related harms, the patterns of relations offer some explanation for the alcohol harms evident in low socioeconomic populations. Certainly, the patterns of relations provide more nuance

and specificity than nebulous notions of ‘deprivation’, ‘stigma’ or ‘social determinants of health’.

The patterns of relations presented possess some explanatory power, but they also provide an innovative methodological example of applied sociological research following lines of causality from the microsocial worlds to the macro scale. I have not done this by deploying a stable, predictable and quantifiable cause of harm, as in the case of the alcohol epidemiology reviewed in the previous chapter. Nor has the scale been achieved by separating data into constituent elements, thematising and distilling them into structural forces, and jumping from the micro to the macro by converging them into a single reality. Instead I have clamped my explanatory chains to specific, observable actors, actants and practices. I have held events together, populating them as thickly as possible with specific empirical details. I have found the macro at work in the micro by identifying large-scale patterns that mediate intimate relations between drugs and bodies and between drug-using bodies. Harms in these studies are not figured as acting upon AOD users as merely biological or social subjects, but instead by an assessment of whether events of AOD use increase or decrease their capacity to express agency, feel and operate in the world.

Finally, the patterns of relations have some promise for policy development and service responses to alcohol-related harms. While research into the action of ‘social factors’ can ground arguments for further regulating the consumption of alcohol, their causal model prevents them from developing new ideas for policy interventions to reduce the harms arising from a given level of consumption. By bringing to light the role played by patterns of relations, arguments for a much wider array of policy interventions become plausible. The next chapter continues this focus on policy, and considers some implications of assemblage thinking for state interventions into drinking practices.

## Chapter 7

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# Drinking culture: an analysis of policy and its impacts

In this chapter, I analyse enactments of drinking culture in government policy documents, and in an Australian Rules football club in Broadmeadows. These different analyses each play a role in the development of an argument about the Good Sports Program, a government-funded policy initiative to change drinking culture in sporting clubs. Using an STS-informed analysis of drinking cultures, I argue that attending to processes of conflict between dominant masculinities can yield insights into the efficacy of the Good Sports Program. I also argue that a more specific engagement with masculinity, and the socio-material networks that hold its manifestations in place, may be useful for ‘drinking culture’ policies and programs like Good Sports to effect more significant change.

The chapter is presented in two sections, each concerned with different enactments of drinking culture: first, in Victorian and Commonwealth policy documents; and second, in a sporting club case study. In the first section, I show that engineering changes to drinking cultures emerged as a policy goal between 2001 and 2012, and that during this process, drinking cultures have been conflated with the orthodox policy levers of supply and marketing controls, and subsequently conflated with public health education. In 2012, a separate cultural change agenda was advanced to address collective drinking norms and processes on macrosociological and microsocial levels. A striking feature of this body of policy documents is the presence of data associating male drinking with ‘harmful’ drinking and the simultaneous absence of initiatives to address masculine cultural practices. A related characteristic is the engagement with culture as a ‘factor’ in modulating consumption, rather than as a social force shaping drinking events. In the second

section, I begin by orienting the case study within the scholarly literature, and propose that single cultural entities have multiple modes of masculinity and associated drinking cultures. I also argue that drinking cultures and masculinities can be co-constitutive, and that both can be understood as networks of meaning held in place by shared sensitivities and common webs of connection between human and non-human elements. In my analysis of the case study data, I demonstrate that the Good Sports Program has strengthened a web of socio-material relations associated with a dominant mode of masculinity and a change in a drinking culture of the club. I also observe a drinking culture and modes of masculinity that have proven resistant to the changes associated with the Good Sports Program. I demonstrate that these versions of masculinity are held in place by two different socio-material networks, neither of which has the agential force to dominate the other. With all of this in place, I advance my argument that a more specific engagement with masculinity, and the socio-material networks that hold its manifestations in place, is necessary for cultural change policies to effect more significant change to drinking cultures in community sporting clubs.

### **The rise of ‘drinking culture’ and erasure of masculinity in alcohol policy**

Periodic public demand for political action to address alcohol-related problems has often resulted in policymakers mounting programs to change the ‘drinking culture’ (Room & Callinan, 2014 p. 3). In this section, I consider the shifting meaning of ‘drinking culture’ in policy documents and the associated shifts in policy initiatives to alter it. I also draw attention to the ways in which performances of masculinity are discernible in these documents as a powerful force in drinking cultures, and to a simultaneous exemption of masculinity from causal attribution and remedial attention. (Manton and Moore (2015) have developed a similar but more detailed analysis of the latter theme.)

Notions of ‘drinking culture’ have become increasingly prevalent in Australian and Victorian government alcohol publications in the last decade. A word coverage analysis of seven Commonwealth and Victorian policy and parliamentary inquiry documents spanning 2001–2012 (Department of Health, 2012; House of

Representatives Standing Committee on Family and Community Affairs, 2003; Ministerial Council on Drug Strategy, 2001a, 2006; Parliament of Victoria Drugs and Crime Prevention Committee, 2006; Victorian Government, 2008) shows a perfect fit of ascending year and ascending coverage, in which coverage is measured by the prevalence of the word ‘culture’ as a percentage of all words in the document, ranging from .01% to .06%. As the political deployment of ‘drinking culture’ has shifted over time, so have the valences of the phrase. The following section of this chapter tracks some of these evolutions.

The earliest policy document reviewed enacted drinking culture as an entity outside the realm of policy intervention. The Commonwealth’s *National Alcohol Strategy* (Ministerial Council on Drug Strategy, 2001b) uses the phrase ‘patterns of drinking’ at several points. It defines the term as ‘aspects of drinking behaviour other than level of drinking.’ Among the list of these ‘aspects’ are: ‘the drinking norms and behaviours that comprise a “drinking culture”’ (p. 3). A companion document, *Alcohol in Australia: Issues and Strategies* (Ministerial Council on Drug Strategy, 2001a) contains a section entitled *The history of alcohol use in Australia*, in which it is stated that ‘over the past century Australia has been depicted as a predominantly male beer drinking culture’ (p. 1), and later ‘The moral and social changes boosted by the temperance, women’s, and labour movements have all played a role in the changes to the Australian drinking culture’ (p. 1). Here, in an enactment of ‘drinking culture’ in twin national policy documents, multiple entities are deployed: ‘Australia’, ‘norms and behaviours’, ‘male beer drinking culture’, and political movements: ‘temperance, women’s, and labour’. While they make some macrosociological observations about drinking culture in Australia, the 2001 Commonwealth documents do not explicitly articulate a cultural change agenda.

In contrast, the successor document, the *National Alcohol Strategy 2006–2009: Towards Safer Drinking Cultures* (Ministerial Council on Drug Strategy, 2006), articulates an imperative to use policy levers to shape drinking culture. It states that ‘Developing Australia’s drinking cultures to produce healthier and safer outcomes is the key challenge for this Strategy’ (p. 2). Within the document’s list of ‘Priority

Areas' is a section on *Cultural Place and Availability*. This section includes the following statements:

The nation's drinking cultures are driven by a mix of powerful, intangible social forces—such as habits, customs, images and norms, and other interlocking and equally powerful, tangible forces relating to the social, economic and physical availability of alcohol—such as promotion and marketing, age restrictions, price, outlets, hours of access and service practices. (p. 26)

This passage contains two significant departures from the predecessor document: the first is the absence of macrosociological masculinity and the second is the introduction of 'tangible' forces. I will now make a more detailed analysis of these two departures.

First, the 2006 policy draws attention to multiple 'drinking cultures' rather than a single macrosociological 'male beer drinking culture', signalling a shift towards the microsocial. On this point, it goes on to elaborate:

There are many different cultures in Australia, especially in relation to alcohol, and different groups attach different values to alcohol and its role in their lives. Culture is about values, the social understandings or rules that connect us, and the importance and worth of various activities, objects and experiences. (p. 28)

This more nuanced view allows for multiplicity, replacing 'culture' with 'cultures', but in doing so, it drops masculinity from the list of entities it deploys to enact the drinking cultures in question. This dispersed and complex notion of culture suggests that targeted and subgroup-specific initiatives will be employed to change different drinking cultures. Looking at the list of those groups singled out for specific concern is informative: the intoxication of Aboriginal and Torres Strait Islander peoples and underage drinkers is specifically mentioned (p. 13) and targeted for dissemination of 'best practice guidelines' (p. 20). However, concerns about cultures of masculine

intoxication are not articulated in the policy, despite the inclusion of a wide range of statistics demonstrating associations between harm and male drinking practices.

These include the following:

- of the 16,756 deaths from acute conditions due to drinking at risky or high risk levels between 1992 and 2001, three quarters (74.3 percent) were male. (p. 12);
- of the hospitalisations with injuries from alcohol-related assaults, 74 percent were male (p. 16);
- alcohol-related violence most commonly occurs in inner-city hotels, in the early hours of Saturday and Sunday mornings, and usually among young adult males (p. 16);
- death rates from road accidents are much greater in rural and remote areas, especially for males (p. 18);
- deaths in Australia from chronic conditions due to drinking at risky or high risk levels. Three quarters (76 percent) of these were males (p. 21); and
- between 1993–94 and 2000–01, there were 87,186 hospitalisations for alcohol dependence, two thirds of which were males. (p. 22)

Ample statistical evidence is provided to suggest that male drinking exceeds the harmfulness and riskiness of other drinking practices, but male drinking and masculinity are not understood to substantively effect or constitute any of the multiple ‘cultures’ to which the policy refers. This erasure has the effect of absencing what is evidently a powerful force in drinking cultures from policy initiatives to change them, leaving the masculinities concerned unchallenged by policy interventions.

A second departure from the 2001 document in the 2006 document is the addition of ‘tangible forces’ identified as shaping drinking culture: ‘Promotion and marketing, age restrictions, price, outlets, hours of access and service practices’ (p. 26). Regulations governing these forces are among the historically orthodox alcohol

policy levers (Valverde, 1998). Bringing them into the fold of ‘culture’ allows the use of well-established mechanisms for the governance of alcohol to be articulated as initiatives for culture change. The 2006 document goes on to state that: ‘Cultural change will require a variety of co-ordinated approaches drawing together stakeholders across many different interrelated sectors’ (p. 28). Arguably, the political advantage of this approach is to allow a broad range of forces to be identified as specifically cultural, without the controversy generated by designating a hegemonic (masculine) culture of drinking as problematic or in need of intervention.

Victoria’s (2008) *Alcohol Action Plan 2008–2013: Restoring the balance* avoids any abstract or definitional discussion of culture, but emphasises the importance of cultural change at several points in the document. The overall aim of the policy is to ‘change the acceptance of intoxication and drunkenness and to reduce risky drinking in the community’ (p. 28). The document states that one of its ‘four key areas’ is ‘culture—sustaining community awareness to encourage a safe and sensible approach to alcohol’ (p. 19). The policy ‘actions’ included under the heading ‘restoring the balance within our culture’ are as follows:

- develop a community awareness campaign;
- support the distribution and uptake of the revised *Australian alcohol guidelines for low-risk drinking*;
- introduce more effective alcohol and other drug education in Victorian schools;
- support the Good Sports Program; and
- introduce warnings on alcoholic energy drinks. (p. 7)

As an expression of policy to change ‘culture’, these actions imply that culture can be changed with rational, evidence-based information, particularly information advocating ‘low-risk drinking’; that is, drinking that does not exceed the consumption levels specified in the national guidelines (National Health and Medical Research Council, 2009). In this document, Victoria’s drinking culture is coaxed towards ‘safe’ and ‘sensible’ drinking practices (defined as less than four drinks on a



single occasion) through ‘community awareness’. By implication, culture is constituted by the rational knowledge of members of a ‘community’.

Victoria’s 2008 alcohol policy includes a striking chart in which male and female numbers are given for ‘Estimated number of lives lost for acute conditions due to risky and high risk drinking in Victoria, 1992–2001’. The ‘acute conditions’ comprise suicide, road crash injury, other injury, other acute medical, homicide, alcohol poisoning, and alcohol abuse and psychosis. The numbers of male lives lost are significantly greater than their female equivalent for all categories. Nonetheless, ‘at-risk groups’ singled out for particular attention are ‘young people; rural and regional populations; people with a mental illness; and Indigenous and CALD communities’ (p. 11). Male drinking and masculine cultural practices are not mentioned as targets for intervention, a critique which Manton and Moore (2015) have also mounted.

The successor Victorian policy document (Department of Health, 2012 p. 17), entitled *Reducing the alcohol and drug toll: Victoria’s plan 2013–2017*, contains a section on ‘Changing the drinking culture’ (p. 17), which begins:

The causes of alcohol misuse are enormously complex and contested. But an individual’s alcohol consumption does not happen in isolation – it is embedded in a context of values, attitudes and other factors that combine to form a drinking culture. As is widely recognised across the community and around the world, changes to law and regulation alone are not enough to reduce drinking problems. More fundamentally, culture change is needed. (p. 17)

Compared with its predecessor document, this enactment pays more attention to an abstract or definitional discussion of culture. The idea of ‘values, attitudes and other factors’ combining to form a ‘drinking culture’ echoes the statement from the 2001 Commonwealth document considered above (Ministerial Council on Drug Strategy, 2001a) which makes reference to ‘drinking norms and behaviours that comprise a “drinking culture”’ (p. 3). Like the 2001 document, the 2012 Victorian policy

deploys a number of entities to co-constitute 'drinking cultures'. Among these are 'the [Victorian] community', among whom 24% 'believe it does some people good to get drunk once in a while' (p. 17); 'relatives and friends' comprising 'social networks' through which 'drunkenness' 'can spread through "social contagion"' (p. 17); and 'young people', among whom 'a culture of excessive drinking is contributing to harm'. This enactment shifts register between the macrosociological and the microsocial and seems to encompass both.

Another way in which the 2012 Victorian policy document's enactment of culture differs from its predecessor is that it positions culture change as a distinct form of intervention and does not conflate it with education and information or orthodox policy levers. In developing this theme, it states that: 'evidence shows the importance of influencing not just individuals, but also the shared behaviour and attitudes of groups of interconnected people' (p. 17). In the 'What we will do' section of the 'Changing drinking culture' section, the policy operationalises its culture change intentions: 'establish a long-term cultural change program led by VicHealth to turn around our drinking culture and support Victorians to make informed drinking choices' (p. 18).

While, of the documents reviewed, the 2012 Victorian document can be considered to be the most engaged and proactive on setting an agenda for cultural change, it has the least emphasis on male drinking and masculine cultural processes. As with the 2006 Commonwealth and 2008 Victorian policy documents, this enactment of culture avoids any reference to male drinking or masculine cultural practices in its enactment of drinking culture. Other than a single table considering 'Single Occasion Risky Drinking by Age and Sex, Victoria, 2010' (p. 19), the document makes no mention of sex or gender.

After examining enactments of drinking culture in Victorian and Commonwealth policy documents published between 2001 and 2012, several observations can be made. Drinking cultures have moved from peripheral, contextual observations into the centre as targets for intervention. This shift has coincided with a shift from a macrosociological enactment of a monolithic, national 'male beer drinking culture'

to enactments that include the microsocial scale of multiple drinking cultures. As cultural change became a policy goal, drinking culture underwent several definitional changes to fit its new role. First it was conflated with the orthodox policy levers of supply and marketing controls and subsequently conflated with public health education. Finally, in 2012, a separate cultural change agenda was advanced to address collective norms and processes on macrosociological and microsocial levels. Another notable feature of the suite of policy documents is a consistent concern with the relationship between drinking culture (however defined) and consumption, rather than a concern with other expressions of culture within the context of drinking practices. An arguably related feature of this body of policy documents is the presence of data associating male drinking with ‘harmful’ drinking and the absence of initiatives to address masculine cultural practices. I speculate that, in the context of articulating an agenda to engineer cultural change, opportunities to intervene in performances of masculinity and alcohol consumption either went unnoticed or were deemed politically undesirable. Anderson argued that ‘By posing as gender neutral environments ... organizations are able to retain male dominance’ (2009 p. 4). Perhaps the rendering of drinking cultures in policy documents as ‘gender neutral’ can itself be explained by a patriarchal dominance of the policymaking process. Manton and Moore (2015) speculated that the gender neutrality of alcohol policy documents is also attributable to ‘a kind of “policy fatigue” in responding to the endemic issue of gender’ (p. 14). Whatever the case, in this chapter I seek to challenge the absence of gender in policy concerning drinking cultures by identifying the central role of masculinity in constituting the drinking cultures of a sporting organisation. In the following section I progress towards this goal through a sporting club case study.

### **Good Sports and hegemonic masculinities: drinking cultures in a sporting club case study**

Focusing on the Good Sports Program, which is designed to change the drinking culture of sporting clubs to reduce alcohol-related harm, this section presents a case study of drinking cultures in a football club. My analysis of interview and field observation material traces interrelations between Program interventions, demographic and social changes, gender hierarchies, drinking settings, and norms

governing alcohol consumption within the club. I demonstrate that changes in the drinking culture of the club rooms have occurred, and that the Good Sports Program played a role in this change. However, 'bad behaviour', 'drink' and 'trouble' remain features of other club settings. I conclude that opportunities exist for further engagements with masculinities and the socio-material networks that hold them in place, and that these engagements would open the way for more significant changes in the drinking cultures of male sporting clubs.

Drinking cultures and associated practices within Australian sporting clubs have been a focus of numerous studies. Most used survey instruments and quantitative analysis to identify the frequency and intensity of drinking among club members and factors associated with variations in these figures (Black, Lawson & Fleishman, 1999; Duff, Scealy & Rowland, 2005; Rowland, Allen & Toumbourou, 2012b; Snow & Munro, 2000, 2006). Attitudes to alcohol use in club settings have also been investigated with quantitative methods (Duff et al., 2005; Snow & Munro, 2000, 2006; Wolfenden et al., 2012). Qualitative studies of drinking cultures in Australian community sporting clubs (Hickey, Kelly, Cormack, Harrison & Lindsay, 2009; Kelly, Hickey, Cormack, Harrison & Lindsay, 2011; Thompson, Palmer & Raven, 2011) have used inductive, thematic analysis of data gathered from multiple settings, an approach common to much of the social constructionist literature reviewed in Chapter 2. Common concerns in the qualitative and quantitative literature include higher consumption than in the broader population, the safety of travel to and from the club during drinking events, the policies and protocols concerning the service of alcohol, under-age drinking, and harm reduction strategies (such as the service of meals). Much of the literature is explicitly concerned with the Good Sports Program, 'a structured intervention that assists community-based sporting clubs to establish policies and practices for the regulation of club alcohol use with the aim of producing a permanent change in drinking customs' (Duff & Munro, 2007 p. 1991). The Good Sports Program was developed between 1996 and 1999 by the Australian Drug Foundation, sporting bodies and other stakeholders (Duff & Munro, 2007), and its implementation began in 2000 (Victorian Government, 2008). Government support for the Good Sports Program is articulated in the successive Australian and Victorian policy documents reviewed above (Department of Health, 2012;

Ministerial Council on Drug Strategy, 2001b, 2006; Victorian Government, 2008). Research literature on the program has also been supportive, with Duff et al. (2005) concluding that ‘the broad, nation-wide roll-out of the Good Sports Program should thus be adopted as a matter of some urgency’. A 2012 evaluation found that accreditation with the program was associated with lower reported overall (i.e. not clubroom specific) alcohol consumption, and as a result, ‘may have the potential to reduce physical injury, and illness significantly, and thereby to reduce the financial costs associated with alcohol consumption’ (Rowland et al., 2012b p. 323). The program functions through a tiered accreditation system in which clubs serving alcohol progress from levels 1 to 3. Criteria for progression through the levels include compliance with liquor licensing laws, bar staff possessing a Responsible Service of Alcohol accreditation, provision of food and low-alcohol beverages while the bar is open, transport strategies to avoid drink-driving, and promotion of the Good Sports Program within the club (Duff & Munro, 2007).

Like the policy documents reviewed earlier in this chapter, studies of drinking cultures in community sporting clubs feature little engagement with masculinity. In contrast, masculinity will be central to my analysis of drinking cultures in the sporting club case study. Before introducing my empirical material, it is necessary to theorise drinking cultures, masculinity and their intersections.

My theorisation of drinking culture involves two interrelated points of departure from historical alcohol studies, one relating to scale, and the other to norms and sanctions. These departures were presaged in recent studies, Kelly et al. (2011) and d’Abbs (2014) respectively.

In the scholarly literature, entities constituting drinking cultures include gender (Kirkby, 2003) and young people (Borlagdan et al., 2010; Roche et al., 2008); situated role contexts (Greenfield & Room, 1997), workplaces (Pidd et al., 2006) and sporting practices (Duff et al., 2005; Hickey et al., 2009; Kelly et al., 2011; Macintyre, 2000; Palmer & Thompson, 2010); policy, industry (Demant & Krarup, 2013) and nations (Greenfield & Room, 1997); and ethnicity (A. J. Gordon, 1978), social worlds (Room & Callinan, 2014) subcultures (Moore, 1990) and

neighbourhoods (Ahern, Galea, Hubbard, Midanik & Syme, 2008). The drinking cultures enacted in association with these entities tend to be stable systems characterised by specific scales of affiliation. When conflict between separate drinking cultures is identified, it is determined by the enactment of boundaries delimiting the particular cultural entities under analysis. In contrast, Kelly et al.'s (2011) qualitative study of drinking cultures in sporting clubs introduced complexity theories from management studies that have much in common with STS and actor-network theory propositions. In their concluding remarks, they stated:

We have imagined clubs as hubs or nodes that are located in complex networks that are shaped by, and shape, things such as the following: geography, social class, ethnicity and demography; social, cultural, economic and technological changes that transform economic activities in localities, family structures and relations, work and consumption practices, leisure and entertainment activities; individual and community perceptions and expectations; the ways in which governments and their agencies imagine and respond to a variety of issues/problems affecting, or caused by, different populations. (p. 481)

Rather than characterise a single bounded entity, Kelly et al. theorised drinking cultures as assemblages of co-constituting and co-constituted entities, with different combinations of such entities enacting drinking cultures on various scales of time, space and affiliation. This approach escapes from the macrosociological/microsocial binary evident in the policy documents reviewed above. Curiously though, Kelly et al.'s study thematises data from multiple clubs, seeking a pathway from the specific to the general via statements that hold across cases. They do not chart their way to the general by attending to the macro acting within the micro, as my analysis does.

Another, related, departure from historical alcohol literature I made in my analysis is an alternate approach to defining drinking cultures as systems of proscriptive and prescriptive norms enforced by rewards and sanctions. The focus on norms and sanctions was articulated authoritatively by Room (1975). In critiquing some literature on drinking cultures (Ahern et al., 2008; R. Gordon, Heim & MacAskill,

2012; Room & Mäkelä, 2000), d'Abbs (2014) argued that, in those studies: 'Drinking cultures are explicitly or implicitly depicted as sets of prescriptive norms linked to sanctions and rewards designed to foster conformity and discourage deviance' (p. 4). However, d'Abbs (2014) finds this account wanting because 'culture is better conceptualized as networks of meanings that are continuously being renegotiated and reconstituted rather than transmitted' (p. 4). This proposal emphasises the processual nature of drinking cultures. Drinking cultures are refigured from an ontic stability (sets of prescriptive norms) to a situated articulation (emergent effects of a shifting field of interacting signs and subjects).

Further scholarly work on the processual nature of group cultures can be found beyond the alcohol field in the realm of STS-informed anthropology. In considering the difference between Corsicans and other French nationals visiting Corsica, Candea (2008) recognised that 'a long line of social theorists ... have conclusively made the case that social groups are effects of continuous process rather than expressions of fixed essences or structures' (p. 204). He followed Latour's suggestion that the durability and obduracy of each social group 'comes in part from the non-human components that are intricately woven into its fabric' (p. 205). For example, he found that, among Corsicans, the non-human components of fires, landmarks, webs of mobile phone numbers, land as property, houses and wind combine into a distributed cognitive process that multiplies, enhances and distributes sensitivities to common concerns among Corsicans. It is these shared sensitivities that set Corsicans apart from others on their island. Nevertheless, Corsicans share much with other French citizens, and variously enact and delimit their affinities on specific scales (national or regional heritage and religious or language affiliations, for example) in specific contexts. This understanding of network process moves beyond a concern with the norms and sanctions within a single cultural entity. Taking Candea's use of Latourian notions of scale and sensitivity, d'Abbs' notion of drinking cultures can be refined to say that the 'networks of meaning' constituting drinking cultures are held in place by shared sensitivities and common webs of connection between human and non-human elements, at various scales of affiliation. This understanding of drinking culture will be applied in the analysis of the case study below.

Masculinity is a further aspect of drinking cultures that appears in the case study below and requires reference points in the literature. In securing a role for masculinity in the case study, I deploy Connell's (1995) concept of 'hegemonic masculinity'. This notion theorises intersections of gender, class, hierarchy and power, and the different subjectivities reinforcing or contesting these normative orders. A hegemonic masculinity is one that is accorded the highest status in a local context, while other subordinate gender and class identities are complicit with or resistant to this regime. Hegemonic masculinity has featured in research into men's team sports and on drinking practices among young men. Anderson (2009 p. 5) argued that men's team sport 'was designed with the political project of promoting men's heteromasculine domination' (p. 5), and that it 'remains a hierarchically driven enterprise whose members proudly boast of its masculinised nature' (p. 4). When hegemonic masculinity has been used in research on drinking practices among young men, it has been argued that 'the use of alcohol and a licence to drink to intoxication are deeply rooted in expectations of male behaviour' (Mullen, Watson, Swift & Black, 2007) and that those who choose to drink moderately or not at all can be assigned a subordinate gender identity (Conroy & de Visser, 2013). Hegemonic masculinity has been used in discussions of class identities too. For example, Lindsay (2006) and Pyke (1996) asserted that lower-SES environments tend to have more rigid gender norms. As noted in the conclusion to the previous chapter, lower-status men compensate for their 'subordinate order-taking position in relation to higher status males' with 'exaggerated masculinity and misogyny' (Pyke, 1996 p. 531). More recently, the interrelations between gender identities and spatio-temporal settings for AOD use have been explored (Farrugia, 2015). Farrugia documented alternative and non-normative masculinities emerging from assemblages of illicit drug use and male bodies in small, intimate spaces such as a bathroom and garage. In this sense, masculinities, like drinking cultures, can be said to be mediated by the settings in which they take place. Drawing together a theory of hegemonic masculinities in the context of drinking cultures in men's community sporting clubs, I suggest that they can be understood as entanglements of drinking cultures, social hierarchies and drinking settings. However, some uses of hegemonic masculinity have been critiqued for essentialising hierarchies and gender roles (Demetriou, 2001) and, in response, it has been argued that deployments of the concept should



emphasise the multiple and contested hierarchies that co-exist within local contexts (Connell & Messerschmidt, 2005). Following this argument, analysis of drinking cultures in community sporting clubs should be sensitive to the presence of multiple hegemonic masculinities.

With these reference points in the literature now in place, this remainder of this section uses data gathered in a Broadmeadows football club as a case study of the Good Sports Program. The case study uses an interview and field notes to explore the impact of this policy, and aims to discuss broader implications for policymaking aimed at changing drinking cultures.

The Broadmeadows Bats, the Australian Rules football club in the case study, has been operational since 1963 and has been located in the Broadmeadows area throughout this time. I learned of the club and their efforts to change their drinking culture through a police officer I met during a committee meeting at the North Park Community Centre. Officials from the club told me that it had participated in the Good Sports Program since 'it [the Program] first started'. I interviewed one official from the club, 'Thomas', with an official from the district football league, 'John', in the clubrooms. Thomas had been involved with the club since early in his (and its) life. At the time of the interview, Thomas served as the volunteer 'Junior Coordinator' at the club and staffed the clubroom bar on training nights during some club functions. John worked as a Community Relations Officer for the football league in which the Broadmeadows Bats compete. His role involved 'community development, youth and junior development work' and engaging 'with different community agencies with the aim of developing relationships that will benefit the [football league]' and its clubs. In addition to material from the interview, empirical material in the following sections is drawn from my observations during a visit to the club for a seniors' match at their home ground during 2013. Several themes identified in the case study were also noted more broadly in the fieldwork observations. These include: the prevalence and frequency of purchasing takeaway liquor; the disinclination to drink within local licensed venues; the increasing significance of Islamic culture; cultural links between expressions of 'Aussie' culture and alcohol consumption; and practices of masculine aggression, particularly

expressed by younger men towards those deemed to be outsiders. These observations suggest that some of the cultural practices noted in the football club observations and interviews extend beyond that context and into the wider Broadmeadows context.

Data from the interview consist mostly of Thomas and John's enactment of the 'official' norms of the club; that is, their account of those norms enforced by club officials. The interview material also includes reference to practices that defy the official norms. The field note data primarily give evidence of practices defying the official norms. Detailing the past and present official norms, and the forces driving changes, is the focus of the first section of empirical material. The second section is concerned with practices defying contemporary official norms.

### ***Changes in the official drinking culture***

Using empirical material from the interview with Thomas and John, this first section discusses the official norms governing the drinking culture of the Broadmeadows Bats from early in its life and contrasts these with contemporary norms. It tracks some of the forces identified as driving this change.

Thomas told me that he had been a regular at the club for many years and alcohol had always been a feature of life there. As a young man Thomas had memories of becoming very drunk and 'going home at 3 o'clock in the morning from these clubrooms, right? Probably not knowing what day it was until the next day when I woke up'. Drinking by young males at the club began at a young age and developed towards heavy consumption before legal drinking age. Thomas explained:

if you take from my time of being here as a kid and stuff, sitting around having a drink and stuff, I'll tell you right now that I'd have a drink when I was fifteen and sixteen 'cos it was just natural here to have a beer and go to my family ... But if I was here and all the rest of it, at the Club you know, it was like, end of season, and under-eighteens not supposed to be drinking alcohol, but thirty-one years ago when I was under-eighteens ... we would have a drink at the end of the season, you know, all sit around with a slab [typically a package

containing 24 cans of 375ml] and drink slabs of beer ... that's what it was like, it was just part of our culture here. We took it as just a natural thing to do, part of your progression as a young person, alright?

While these norms were permissive in the sense that 'under-eighteens [are] not supposed to be drinking alcohol', drinking culture at the club was not without its proscriptive norms and sanctioning practices. Thomas described how a more senior member of the club would enforce some standards of decorum during drinking events:

I'm the oldest of three boys, three years apart, and when we have a drink, we get happy and it's time for clothes to come off ... anywhere! It doesn't matter where it is, it seems to be a family trait ... We've got this thing in our DNA, I don't know ... and we'd have a disco here or something like that and [name], the president of the Club now, he wasn't the president then, but he's been here longer than I have. His family's been here since we were here in '63. He would see me starting to do this [undressing], so while I'm [un]doing these ones [buttons] ... he'd be doing these ones up and telling the person behind the bar, "no more drinks for Thomas". Alright? So we looked after each other, and that's what it used to be like ... It's like a big family. I regard the [Broadmeadows Bats] as my family, so we all look out for each other and people would, know you, over time, even before this Good Sports stuff happened, you'd know the people ... what they could and couldn't do.

Taking clothes off during drinking events was apparently a common practice for Thomas and his brothers, but even before initiatives such as the Good Sports Program, it was gently admonished by more senior club male members and could be enforced by denying the person concerned further drinks. 'We look after each other' was an operative ethic during drinking events and Thomas understood the interventions in that light. However, norms around the removal of clothes were

sometimes breached, and Thomas told stories of ‘guys falling asleep naked on a Saturday night at the Club you know, and families coming here the next day and seeing that’. Thomas was keen to point out that these practices were no longer part of the drinking culture of the club. Thomas’s role as one of the drunken revellers has now been superseded by a role of serving alcohol on Thursday (training) nights and during some functions. He indicated that the norms he enforced in this role were no longer associated with removal of clothes, but with the regulations governing responsible service of alcohol (RSA). He explained:

over time we’ve progressed and we’ve got smarter and more diligent about what we serve and who we serve and how much they’ve had. It’s like you’re policing the bar—what we’re really doing when we go and work behind there—that’s why you don’t have too many people doing it. So you’ve got like half a dozen people with their RSA accreditation that are here on the night drinking when we have functions, so that you know and keep an eye on people all the time; so you can tap someone on the shoulder or say to their mate, “look, so-and-so’s had enough now, we’re not going to give him any more drinks, or her any more drinks”, and that’s the night. Now that might not have happened 25 years ago. I can guarantee it wouldn’t have happened 25 years ago.

Thomas explains here that contemporary norms governing the service of alcohol were concerned with ‘how much they’ve had’ rather than issues such as removal of clothes. Those serving alcohol are accredited to do so and they ‘keep an eye on people all the time’. This distinct shift in the norms governing drinking in the club, and their enforcement by dominant males, was motivated by a range of forces and had a range of effects. These forces and effects are my next focus.

The Broadmeadows Bats signed up with the Good Sports Program ‘when it first started’ and had achieved level 3 accreditation at the time of interview. This process was associated with a change of customs at the clubroom bar. Thomas explained:

if you're going to be selling drinks, once you're a [Good Sports] level 3 club you can provide food and meals while you're doing this. So tonight we have meals for \$5 or \$10 ... they encourage you to have food and non-alcohol, free water for the people working behind the bar, all those sorts of things. So it's not discouraging you from selling alcohol, but it's encouraging you to have other options for people to have, and make sure that you have just as many options of non-alcoholic drinks as you have alcoholic drinks.

Accreditation in the Good Sports Program motivated the club to provide food and non-alcoholic drinks during events. It was also associated with other changes at the club: during the interview Thomas drew my attention to Good Sports branded signs on the clubroom wall reading 'We are a Good Sport accredited club'. He also told me that the club had hosted Good Sports Program related information events for people from other clubs: 'people come here and do about an hour and a half course. It goes through all the responsibilities you have as a Club and as an individual for serving alcohol and that.' There are policy development requirements: 'you'll have a smoke-free policy and you'll have an alcohol policy, then you'll have your taxi service, like we have a [the phone number for a] taxi [service] up on [the wall] there.'

Accreditation comes with the promise of material benefits. Thomas explained: 'It also helps you out with sponsorship and that when you go to get grants from the Government and other places, that you can go and say that we're here because it's a recognized program'. While Thomas did not specify any particular funding arrangements that the club had accessed as a result of accreditation with Good Sports, he clearly understood that there was a potential advantage to the club in that respect. Compliant service of alcohol, the addition of food and non-alcoholic beverages to the bar menu, signage, information events, policies, taxi numbers and a greater range of potential funding sources were all effects mediated by the Good Sports Program accreditation. Clearly, Thomas associated these changes with a change in the norms governing service of alcohol in the clubrooms, but there were other forces at work in changing the drinking culture too.

Thomas told me that the Broadmeadows Bats had established a reputation for being ‘a little bit rough and all the rest of it’: ‘We’re no better or worse than a lot of clubs in our area, but we’ve always carried a black mark against us ... we are the club that has the worst reputation, alright?’

In the wider contemporary cultural environment, the reputation of the club had begun to cause it some difficulties. We might take Thomas’ ambiguous term, ‘rough’, to refer to the club’s drinking culture, but given its location within a socioeconomically disadvantaged area, and the analytic orientation of this paper, we might read ‘rough’ to be also entangled with class, material circumstances and the dominant forms of masculinity within the club. Thomas explained that the club was experiencing difficulties attracting junior players: ‘[At the beginning of the 2013 season] we had four kids playing football—well, they weren’t going to be playing football—we had no junior club.’ John, from the district football league, explained that: ‘these guys [the Broadmeadows Bats] have recognised now that for their club to survive into the future, that they need to make it a more family-oriented club.’ He elaborated:

This club would not be existing in the [football league] right at this moment if they had not come together; the president, or the CEO of the [football league] and a couple of other board members, Thomas himself and other people helping us from the Association. They met with us on numerous occasions to nut a plan out, but we had to buy into it and we had to make sure we stuck to what we said we were going to do.

Difficulty in attracting young players into the junior teams had become an existential threat to the club, and a response the club officials and the football league developed was to become a ‘family-oriented club’. Attracting families was evidently also a concern for other clubs: all 11 clubs (including two football clubs) participating in Hickey et al.’s (2009) qualitative study of sporting club drinking cultures ‘identified steps they had taken to present themselves as family friendly environments’ (p. 19). As noted above, Thomas explained that some of his formative experiences at the club

had included his brothers, and that the club was like a 'big family', and that meant looking out for each other while drinking heavily, but this is not what is meant by being a 'family-oriented' or 'family-friendly' club. Hickey et al. (2009) gave a clue to the valence of this term in their observation 'that steps [to become family-friendly] were positioned as central elements of trying to break down the negative characteristics, actual or perceived, commonly associated with "blokey [masculine archetype] sports"' (p. 19). Among Hickey et al.'s participants, a family-friendly orientation was distinguished from a 'blokey' one. The notion that 'blokey' performances of masculinity are anathema to the presence of women and children is in line with observations in other studies. Palmer and Thomson (2010) characterised their field site of a social group of supporters in a South Australian football league as 'an aggressively male environment' in which 'women were largely absent' (p. 433). The supporters sang 'drunken, sexist, racist and homophobic songs' and 'referred to ... women in highly derogatory ways' (p. 433), offering an example of a hegemonic masculinity as one which 'is asserted by denigrating "others" who are not present' (Gough & Edwards, 1998; Mullen et al., 2007 p. 152). Thomas elaborated on his meaning of 'family-friendly' when he said:

just touching on the family-oriented stuff, this year, we had a change of leadership at the Club ... The first thing he did was [say] "we're being a family club", no bad behaviour, drink or whatever was going to be tolerated; that anything happened on the field will be dealt with by the Players Group [a formally convened group of players], and anything happened off the field, whether it be drinking or whatever else, would be dealt with by the Committee. So all the functions that we've had this year have all been promoted and other times have been too, but this year's been a big focus on family-oriented functions. And everyone's here, we've had no trouble—and I can guarantee that every year at one of the functions there'll be a problem—there always is, it just goes with the territory. But because we've been so vigilant this year, everyone's said how fantastic—we had eighty to a hundred people in here both functions this year—that we've had in the rooms and still had alcohol here, but we had food here and everyone brought

their wives, girlfriends and children with them. And we all had a very, very good night.

I infer from this that being a ‘family-friendly’ club means that women and children are catered for, particularly with the provision of food; and that performances of masculinity involving ‘bad behaviour’, ‘drink’ and ‘trouble’ are not tolerated (and would face sanctions from ‘the Committee’). In light of the analytic orientation of this chapter, we can read the change in club President, and in the dominant norms concerning comportment during clubroom drinking events, as a change in the ascendant form of masculinity at the club. For the Broadmeadows Bats, the Good Sports Program had been in place for some time, but orchestrating an atmosphere free from aggressive performances of masculinity required the intervention of a new club leader, and the ascension of new norms of masculinity, which laid down clear processes for sanctioning men who deviated. In Kelley et al.’s (2011) qualitative study of alcohol use in community sporting clubs and among the club members they interviewed, ‘women are seen as civilizing influences who often moderate the excesses of a male space and make it more attractive for families to encourage their kids to participate’ (p. 481). The analyses here suggest an alternate reading, that the ‘civilising influences’ are instead associated with a hegemonic mode of masculinity that provides for the safe and comfortable inclusion of women and children. I observe that ‘family-friendly’ practices do not pose a threat to the hegemony of masculine practices at the club, or to the masculinist nature of Australian Rules Football, but merely sanctions particularly egregious performances of aggressive masculinity.

The Good Sports Program and an imperative to alter the club’s reputation and attract a viable pool of players effected this change to the regime of masculinity in the Broadmeadows Bats’ clubrooms, but other forces were at work too. Also driving change in the drinking culture were the demographic changes in the local area, particularly an increase in the Islamic population. John explained:

over half of the population in Broadmeadows currently speaks a language other than English at home ... Now that’s only going to



grow and of those populations, a big proportion of them are Islamic, Turkish, Syrian, essentially Islamic population, so yeah—massive part of the population.

To remain sustainable, the club needed to recruit from the local community which, increasingly, included people of Islamic faith. John explained that the Broadmeadows Bats had tried to attract members by waiving entry fees for ‘newly arrived’ families and having printed materials translated into other languages. Thomas explained that he and his club members had adapted some of their training practices to comply with Islamic customs. These included accommodating religious festivals: ‘having parents ringing up and explaining that my son won’t be here because we’re going through Ramadan and he might not play on the weekend because he can’t eat and drink during the day and so on’; and different norms regarding alcohol:

we’ve got people that still like a drink here and I’m not going to shy away from the fact that, like all clubs, we’ve got people who like to have a drink. And that’s one of the things that when you walk up—we’ve only got a small little verandah, so this is the entry here—when you bring new people here, you’ve got to be aware and have an eye open, talk to people and not make it so obvious that you’re doing it there, having a drink. Go down the end of this verandah or something like that when we’ve got people here. ‘Cause that is it with Islamic people and so on, it is a big thing in their culture.

While Thomas explains the visibility of alcohol consumption here as a disincentive for Islamic recruits, one wonders how much of a disincentive this was likely to have been in its own right. I instead speculate that hegemonic modes of masculinity that position non-drinking men in a subordinate gender category, which have been observed elsewhere (Conroy & de Visser, 2013), would make recruiting from an abstinent community more difficult. In either case, the change in regime at the Broadmeadows Bats was all the more necessary for the changing demographics of its local area.

Other forces altering the norms governing drinking cultures at the Broadmeadows Bats are ‘booze buses’ (which police use for roadside blood alcohol content (BAC) breath testing) and ‘responsibilities’. Thomas explained that the young players of today have:

different social needs and all the rest of it, from what players in the past did. Beforehand they weren’t worried about booze buses and whatever else, so they could sit here all night if they wanted to, now they all got responsibilities and other things they go and do. They go home at 9.30[pm]. There’s no staying here till eleven o’clock. I haven’t stayed here till eleven o’clock for about five years.

Thomas makes two points here, one about transport and one about the ‘social needs’ and ‘responsibilities’ of male players. Road safety, particularly drink-driving, has been a major focus of Victorian policy in recent decades and these efforts are recognised as having been successful, although ongoing surveillance and enforcement remains a priority (Department of Health, 2012 pp. 12–13). Drink-driving is a primary concern in the literature on drinking cultures in sporting clubs (e.g. see Hickey et al., 2009; Snow & Munro, 2000, 2006), and Duff et al. (2005) reported that sports club members who drove their cars home from the club drank an average of 4.5 standard drinks per session. Thomas pointed out that players’ concerns about roadside BAC testing by police, or ‘booze buses’, have had an effect on drinking practices at the club. There is little in the interview material or field notes to guide speculation about the ‘social needs’ and ‘responsibilities’ Thomas refers to, but the increased prevalence of women’s employment and an associated increase in family responsibilities borne by fathers of young children are among the more pronounced social changes of the last 50 years (Hughes & Stone, 2003 p. 42); these may be among the forces to which Thomas alludes. The combination of family responsibilities and increased surveillance and enforcement of drivers’ alcohol consumption would account, in part, for the change in drinking culture Thomas has observed.

To summarise the contemporary Broadmeadows Bats' official drinking culture, we can say that it is an effect of a web of connections between the team clubrooms, the Good Sports Program, the football league, and socio-material changes in the local area and beyond. These webs of connection effected, and were reinforced, by the ascension of a new leader in the club, and a new regime of hegemonic masculinity, which enacted processes for sanctioning those who failed to be bound by it. The new regime empowered bar staff to enforce the RSA regulations, and discouraged performances of aggressive masculinity and obvious alcohol consumption on the verandah. It materialised in wall-signs, taxi numbers and the provision of food and non-alcoholic beverages in the clubroom. It drew previously excluded human elements into the clubroom too, particularly women, children and people of Islamic faith. Outside the clubroom, responsibilities drew players home earlier, and processes of governmentality and state coercion induced members to avoid drink-driving.

It may be that Thomas's account of drinking culture in the clubrooms emphasises change more than continuity. Given the small amount of data I collected, I am cautious about inferring too much about the extent of changes achieved. However, the club's long-standing level 3 accreditation with Good Sports, and evidence from other Good Sports-accredited clubs, would suggest that it is likely that changes in the clubrooms have taken place (Rowland, Allen & Toumbourou, 2012a) and that these changes are likely to be more evident in the clubrooms than elsewhere (Hickey et al., 2009). For these reasons, in the following sections, I will proceed with the assumption that different norms govern drinking practices inside and outside the clubrooms.

### ***Outside the clubrooms***

So far, my analysis of the empirical material has covered the official account of the Broadmeadows Bats' drinking culture in the clubroom. This next section introduces empirical material from beyond the clubroom to highlight the multiple drinking cultures within the Broadmeadows Bats and the ongoing contest between them.

In July 2013 I attended a Broadmeadows Bats game at their home ground. The Bats' senior team were humiliated on the field and scored only one goal during the game,

which is highly unusual in Australian Rules football. The visiting team's supporters outnumbered the Bats' supporters. My field notes record some contrasts between the two groups of supporters:

The other team, I really didn't see any of their supporters drinking ... On the right, the support base for Bats were all drinking, gathered together, and they were vociferously abusive whenever players from the other side came past. The other side were quieter, [but] they were encouraging when their team scored a goal, which was often. They were more moderate in general. There were more kids with them.

The field notes also contain a closer description of the Bats supporters, a group of about 20 people gathered against the boundary rail, away from the clubrooms and near a muddy corner of the car park:

They were all drinking packaged liquor that had been bought elsewhere. There was a couple of boxes of Black Douglas [Scotch whisky] and cola on the ground and a couple of cooler bags, a six-pack of Carlton Draught [full strength beer] and a man was drinking another sort of beer. The females were outnumbered by about two to one ... The men tended to stand up against the rails and pretty much all of these people had alcohol in their hand all of the time. The men stood there talking about the football, talking about cars, about the AFL [the professional Australian Rules football league], about the game in front of them. Whenever the ball came near to them they shouted abuse at the other team ... There were a couple of men in particular who were drinking quite heavily and were being quite rowdy. One of them, who had tattoos on his neck and on his face, was quite an intimidating figure and was the most vociferously abusive.

These observations illustrate the difference between drinking norms inside and outside the clubrooms. Family-friendly practices were not evident among this group of supporters: performances of aggressive masculinity likely to intimidate women

and children were starkly apparent. Supporters of the visiting side seemed to create a more family-friendly atmosphere and their lack of drinking and abusive vocalisations coincided with a larger support base and greater on-field prowess. Further evidence of disparity with the clubroom norms can be found in my field observations from the boundary rail:

There were a group of about five young men. I was standing near them during the final quarter of the game trying to hear what they said. One of them was a [Bats] player who had come off the field. He'd played on the field at one stage but at the start of the final quarter he was [no longer playing and was] offered a[n alcoholic] drink by one of this group ... This player, during the final quarter, was standing there in his footy boots and his shorts, holding one of these drinks and drinking it. They were talking about what they were going to do tonight. There was a bit of discussion about who was going back to [a member of the group's] house. One of them had made an invitation and there was also a push to go to [a licensed venue in an inner northern suburb]. They'd been to [the same venue] last weekend and I heard one of them talk about how, 'you were legless [alcohol-intoxicated, with impaired bodily coordination] last weekend dude, you were legless.'

Of the same group, I later observed:

When the game finished, one of the group ... hopped in the driver's seat of [a car] and the car filled up [with young men]. The guy who had been playing, who had been offered the drink after he came off the field, he told them, 'I'll just go to my car and get my wallet and then I'll come with you and we'll buy a bottle on the way' ... Another car pulled up and the guy who was driving said, 'oh, we're off to his place', indicating one of the men in the back seat, 'we're going to get on it, I'm drunk' ... He drove off and turned left and left the football ground.

These observations suggest that heavy drinking after a football game remains a practice among Broadmeadows Bats members, but that this practice does not occur at the clubrooms, as it did when Thomas was a young man. Instead the drinking began at the ground, then moved to a private home or licensed venue. The observation also suggests that police surveillance and enforcement of drink driving laws have not altogether discouraged club members from drink-driving.

The field notes record that ‘the clubhouse was empty and didn’t see a lot of use [during the day]’. Most of the alcohol I saw consumed was brought in from elsewhere, although a small quantity was sold by the club from plastic ice boxes under the verandah. During the interview, Thomas acknowledged:

we’re not going to sit here and say we’re up in lights and I want to be on television tomorrow saying we’re perfect, because we’re far from it. We still have our issues here at the Club that people think they can still go ahead and drink too much and whatever else, but the difference is they used to do it here [in the clubroom]. Now they do it over there [in the car park].

Thomas suggests here that the changes in norms governing drinking practices are more applicable to the clubroom than to other settings. In their study, Hickey et al. (2009) observed that ‘The bar was widely seen as the easiest place to regulate drinking’ (p. 21), but ‘most of the clubs we spoke to recognised that their sphere of influence had to go beyond just monitoring the bar’ (p. 20). While Thomas also clearly recognises that drinking practices outside the clubroom remain an issue for the club, changing these practices is difficult. Thomas explained:

Once you go down the stairs [from the clubroom], that becomes a Council issue, right ... I’d like to say we’d be able to control [drinking], but there’s no way in the world that you’re going to do that unless you’ve got specific people in the Club, if you’ve got a big lot of people who can go around and tell people and ban them. And it’s

always hard to ban people 'cos if you've got a public place—you really can't go—council has to ban them, the club can't ban them. We encourage them not to come, we can't stop them from coming.

Here Thomas expresses ambivalence about enforcing the official drinking norms outside of the clubroom, and defers responsibility for enforcement to the municipal authority. Local law enacted by the municipal council forbids the consumption of alcohol in a public place (Hume City Council, 2013), but Thomas's account and my observations suggest that enforcement of this law is not effective. Thomas mentions the possibility of banning repeat offenders from the ground, but again demurs about the authority of his club to take this step. Removing people from community sporting clubs for failure to adhere to newly imposed norms has precedents, with Hickey et al. (2009) quoting one of their participants as saying: 'I think through some changes made by the club was just to try and clean it up and rid itself of people we didn't want around the club'. Evidently, the Broadmeadows Bats have been more ambivalent about taking this step.

Thomas explained that among the reasons for the obduracy of the practices of those who 'go ahead and drink too much' are the continuity of family ties, and an ongoing affection between long-standing members. Thomas explained:

some people will resist change and progress, and we have got the old guard there and they've got their kids and their family members and stuff, and they've always drank. With my father and my father before me, we all drank, right and we all like a beer on a Saturday afternoon watching the football—so it's become ingrained ... These are the harder people to try and work on—and I'll just say that's what that group is—they'll just sit over there [pointing towards the corner of the car park where I was to see the Bats supporters gathered]. I know the families myself, alright, I've had run-ins [conflicts] with them before over the years. Sober—loveliest people you'll ever meet and I have a great conversation and a chin-wag [informal discussion] with them, but their culture is ... what they've been handed down over time.

Thomas's earlier statement about the club being 'like a big family' also suggests an enduring connection between long-standing club affiliates and willingness to endure difference and discord. Thomas gave further reasons for the durability of 'ingrained' drinking cultures when he explained that past club officials have had a different view of the Good Sports Program:

I've got one man here that despises Good Sports and he's been President of the Footy Club and I'm not going to mention his name, but I'll just say that he and I get on well and I've coached his son over many years, or his sons over many years. But he just thinks that Good Sports is a big waste of time and a bit of a con job [dupe or swindle], so you've still got those aspects too with people.

If past club officials remain ambivalent about the new drinking norms then it may be that the new regime in the clubrooms barely holds. Had it not been for the recently realised existential threat posed by the club's 'rough' reputation, even the changes in the clubroom drinking norms may not have been achieved. However strong its grip, the ascendant mode of masculinity in the clubroom, and the network of forces that holds it in place—the bar, bar staff and their RSA training, food and non-alcoholic drinks, wall signs, taxi numbers, women, children, and accommodation of Islamic culture—do not exert the same agency outside. Outside, another web of connections—takeaway alcohol products, the football ground and its car park, non-enforcement of council regulations, and fealty to familial masculine practices—affords the hegemony of a different masculinity. From time to time, the hegemonic mode of masculinity inside the clubrooms and its counterpart outside have come into direct conflict, in the form of 'run-ins'. Attempts by club officials to bring non-compliant men to heel have been unsuccessful, as the network of elements empowering them is insufficiently agential to extend their hegemony outside, and the web of connections enabling the outside hegemony is sufficiently obdurate and robust to resist attempts to unseat it.



## Conclusion

In the Broadmeadows Bats' clubrooms, the dominant masculine norm is to drink moderately and without aggression, in a manner that does not inspire alienation or fear in women, children or people of the Islamic faith. The dominance of this mode of masculinity is held in place by a network of socio-material elements: the Good Sports Program wall signs, taxi numbers, food, non-alcoholic beverages, bar staff with RSA accreditations, the demographics of the local population, booze buses, and the institutional authority of the football league and club officials such as Thomas and the Club President. In a muddy corner of the carpark, a different expression of masculinity holds sway, and this one drinks heavily and behaves aggressively. The dominance of this mode of masculinity is held in place by a different network of socio-material elements: takeaway alcohol products, the football ground and its car park, the football club and its history, lack of enforcement of council regulations, and continuity of historical norms—particularly modes of masculinity reproduced within families. While the Good Sports Program and the Commonwealth and Victorian policy documents that underpin it have succeeded to the extent that they have played a role in changing the official drinking culture and the dominant masculinity within the clubrooms, problematic drinking practices endure in the carpark and other locations in which the players and supporters gather after a game.

Foregrounding the roles played by masculinities within the Broadmeadows Bats shines new light on drinking cultures in community sporting clubs, the Good Sports Program and the broader policy settings concerning 'drinking cultures'. First, it displaces the simplistic attribution of aggression, 'bad behaviour' and 'trouble' to alcohol, and suggests instead that gender hierarchies and their enforcement should be made more accountable for these problems. Second, it highlights that the drinking cultures of community sporting clubs are the results of ongoing contest and controversy, rather than static and reified rituals. As noted by Kelly et al. (2011) and Rowland and Toumbourou (2009), club officials play a decisive role in these contests, and the Good Sports Program has added to their power to effect change. However, in my case study of the Broadmeadows Bats, the effects of the Good Sports program are less evident outside the clubroom bar, and there is some evidence that this is the case in other clubs too (Hickey et al., 2009).

Recognising that a change in local hierarchies of masculinity can change drinking cultures, and that government policy can be shown to alter the socio-material networks that hold hierarchies of masculinities in place, offers policymakers some novel opportunities for mitigating the co-occurrences of ‘bad behaviour’, ‘drink’ and ‘trouble’ in community sporting clubs. Further studies might generate ideas for interventions to stack the odds in favour of some hegemonic masculinities and not others. More radically, further interventions might explore possibilities for the institutional empowerment of women and men from traditionally subordinated subjectivities to occupy positions of cultural and institutional leadership within community sporting clubs, further disrupting the hegemony of aggressive masculinities.

At this stage of the thesis, I have applied this productive analytic strategy—attributing the effects of drinking events to socio-material networks—to four sites: alcohol epidemiology, young adult drinking events, alcohol policy concerned with drinking cultures, and the Broadmeadows Bats football club. The final site in my ethnographic field—The Northern Suburbs Drug and Alcohol Clinic—is considered in the next two chapters.

## Chapter 8

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# Enactments of AOD in a clinical AOD treatment setting

In this chapter and the following one I analyse ethnographic data collected at an AOD treatment clinic providing services to young adult heavy sessional drinkers in Broadmeadows, as well as to other client groups. Using techniques from STS, I detail enactments of alcohol and other drugs, and of clients and their life circumstances. The current chapter is concerned with the former enactments, while the following chapter is concerned with the latter. I argue that different modes of ordering realities in the clinic can be categorised as *aggregated*, *humanist* and *situated*. The aggregated realities emerge from clinical science, and are held in place by diagnostic nosologies, guidelines, disciplinary demarcations, and devices for inscribing conditions such as mental health problems. These enactments have the political consequence of positioning AOD use, including heavy sessional drinking in the context of criminal offending, as the *sine qua non* of difficult life circumstances. Aggregated realities are often set aside by those clinicians who prefer *humanist* enactments in which their service provision is rendered as a benevolent response to clients' unmet material and emotional needs. Humanist enactments open channels of resources for clients, and acknowledge more fluid causal flows between AOD use and difficult life circumstances. However, actual clinical interventions remain limited to addressing AOD use, directly or indirectly. This has the consequence of making clinicians complicit in relegating material and social disadvantage to the background, while foregrounding AOD as the source of life problems. Clients sometimes resist both aggregated and humanist realities and advocate for fully situated accounts of their circumstances. These understand the effects of AOD use to be transformed by emotional, social and material entanglements and resist the foregrounding of AOD use as *the* problem in their lives. Each of these realities represents political claims about the nature of AOD use, and each is held in place by a suite of prior assumptions and vested interests.

In developing these arguments, I use techniques adopted from STS to detail the ontological productions of AOD treatment. My analyses are guided by Mol's (2002) STS-informed medical anthropological study of atherosclerosis in a single hospital, which was introduced in Chapter 3. Mol's work describes the practices, disciplinary enactments, inscription devices and institutional relations that enable and co-produce the enactment of disorder and disease in a single treatment clinic. Mol's (2002) work describes the *modes of ordering* atherosclerosis. These include arrays of sensitising instruments and processes that render patients' leg veins articulable to their doctors: the means through which doctors make sense of their patients' discomfort and suffering, and through which they determine a course of therapeutic action.

Similarly, these chapters document the modes of ordering problematic AOD use: the means through which AOD clinicians become sensitive to the forces that mediate events of consumption and harm, and through which they determine a course of therapeutic action. The analysis in this chapter demonstrates that AOD clinicians are highly sensitive and articulate about their clients' circumstances. It follows their use of psychometric instruments, lists, protocols, clinical wisdom, inter-agency contacts, disciplinary paradigms and heuristics to form complex, multi-dimensional accounts, and to form therapeutic plans of action. Latour (2004a) and Mol (2002) argued that technological and embodied instruments for registering differences (like those used in AOD clinical practice) do not describe a single entity with more or less accuracy, but that they enact that entity multiply. As different enactments of the 'same' entity multiply, we become more sensitive, more articulate, and better able to respond. As multiple enactments accrue, they generate controversies about the ontology of their entities of concern. In these chapters, I do not seek to prove that dominant modes of ordering heavy sessional drinking and other AOD use by young adults are incorrect, or to resolve any controversies. Instead, analyses in these chapters seek to examine controversies in order to generate productive insights into alternative potential formulations of AOD treatment for young adults and associated research priorities.

Several examples of ethnographic studies of Australian AOD treatment settings have been published. Chenhall (2008) used ethnographic methods to examine the informal aspects of a treatment program in an Indigenous residential AOD rehabilitation

service. The study aimed to inform evaluation designs that typically measure abstinence, length of treatment, or other officially recorded information, in order to detail more complex and layered meanings of treatment for clients. In particular, the study identified oscillating periods of mutual support and discipline as significant dimensions of treatment currently overlooked in evaluations. Foster, Nathan and Ferry (2010) also sought to contribute more nuance and qualitative depth to understanding of what constitutes ‘success’ among AOD treatment clients. Their study of a therapeutic community for AOD-using adolescents considered areas of program operation that are not typically considered in evaluation design. For example, they developed concepts of ‘navigating’ and ‘engagement’, which have been used as binaries in evaluation literature, and proposed that they be thought of as a ‘continuum with residents moving between the two at different times and with different activities’ (p. 537). Roarty et al. (2012, 2014) used ethnographic research in a youth AOD treatment setting to construct a qualitative tool for measuring young people’s progress in treatment. While there are numerous treatment measures for adults, the authors note a paucity of measures that provide ‘developmentally informed approaches to treatment research with alcohol abusing teens’ (Roarty et al., 2012 p. 718). The study details a rubric for tracking behaviour change, similar in some ways to Prochaska and DiClemente’s ‘transtheoretical model’ (1986) but developed specifically for adolescents. While each of these studies noted that those receiving treatment for AOD use typically experience a complex array of social and economic disadvantages—and the prevalence of unemployment, disengagement, unstable housing, mental illness, social isolation and family conflict and among those receiving treatment for AOD use is well known (Howard, 1993)—the ethnographic studies listed above do not problematise the foregrounding of AOD use as a causal agent in life circumstances. In these chapters, I question this apparently incontestable assumption and the consequences of its specific formations. I will show how this foregrounding acts to produce specific realities, and question their being taken for granted as part of the natural order.

Whereas in previous chapters I have presented disciplinary enactments separate from their counterpoising ethnographic sites, this disciplinary site and its counterpoising site are folded into one another in such a way as to require their mutual inclusion

within the same body of text. This chapter presents a range of controversies within the same site, drawing distinctions between the enactments of clinical science and the contrasting, situated or humanist enactments in the NSAODC. These controversies are presented in the sections of this chapter concerning ‘primary drug’ and dosage.

The NSAODC headquarters is located in a northern Melbourne suburb, but the agency provides services in several locations. Some of the programs are funded to cover populations in the northern suburbs, including Broadmeadows, while others are statewide. The service offers counselling, withdrawal, relapse prevention, family programs and educational programs for people on court orders. The counselling programs are designed for specific client groups. These include adults, youths and forensic (court ordered) clients. Withdrawal programs are offered in three versions. One is an inpatient program offering 7–14 day stays for 12–21-year-olds, another offers similar-length stays for adults, and a third offers outpatient support for clients doing withdrawal at home. The first two offer medication, education, rest and group discussions. The latter involves AOD nurses visiting the home, liaising with doctors and family members, providing advice on appropriate medication and so on. The relapse prevention services take the form of facilitated weekly group meetings discussing a six-week cycle of topical matters. Programs are provided for families of people with AOD problems; these include a support group that meets once per month, single-session family therapy, ongoing family therapy, and multiple playgroup programs targeted at ‘disadvantaged families’ who are affected by AOD issues. Finally, the service provides two-hour educational programs for people on court orders. These include courses on cannabis, drink-driving and illicit drugs. In addition to the services provided by the agency, clinicians routinely provide referrals to a wide range of other services including residential rehabilitation programs, telephone drug advice lines, mental health services, pharmacotherapy prescribing doctors and housing services.

The three clinicians I interviewed at the NSAODC work in different programs. I will call the clinicians ‘Wal’, ‘Violet’ and ‘William’. Wal leads the outpatient withdrawal program, and is qualified as a nurse. Violet’s service is based in Broadmeadows and offers voluntary AOD counselling and education to young people (ages 12–26) and

their families. William works across two sites and two programs. One program is funded through the justice system and provides AOD counselling and assessment to forensic clients. He sees many of these clients in an office in Broadmeadows. The other program is sited at the organisation's headquarters and involves AOD counselling for voluntary clients. The researcher I interviewed, Reginald, identifies AOD issues and designs service models, which are then used to apply for funding. If applications are successful, he develops the models further for implementation.

Many of the data presented here were gathered during clinical review meetings. Clinical review meetings are held daily and typically involve between five and 10 clinicians gathering in a meeting room and taking turns to introduce the details of a client who has been assigned to them. The client details are gathered during an intake assessment, which involves a clinician and client completing a standard questionnaire and discussing the client's AOD issues and broader life circumstances, typically including information about a client's previous AOD treatment history, their accommodation, employment and family circumstances, presenting and historical mental health problems and treatment, and other medical, psychological or welfare services they might be receiving. The purpose of clinical review meetings is to develop a treatment plan for each client. After the client's circumstances are described, the group considers courses of action. These might include recruitment into any of the treatment programs described above, or advocacy with any of the other services and authorities handling the client. An important element of this process is the inclusion of multiple disciplines. While training in AOD counselling was common to most staff, the meetings I attended sometimes included people trained in medicine, pharmacology, social work, psychology, management and family therapy.

### **An extended case study and its significance**

This chapter and the next are structured around a case study of a single NSAODC client's clinical review. The selection of the case study and its analyses were completed after the situational analysis procedures (detailed in Chapter 4). In this section I describe the case study analysis and justify the significance of the conclusions that emerge from it.

My extended case study approach begs two questions: first, at what scale can the significance of my conclusions from my case study approach be claimed? And second, why use this particular case? In response to the first question and as I suggested in Chapter 3, STS-informed analysis holds events together and populates them as thickly as possible with specific empirical details. Its significance is achieved by animating the macro within the micro. In keeping with this approach, case studies have been employed in STS-informed empirical studies to develop accounts of clinical and therapeutic realities. One example is Mol's (2002) use of case studies in her study of atherosclerosis. Another is Moser's (2005) case studies in an article concerned with the ordering of disability, or 'how people become, and are made disabled' (p. 667), and what the possibilities for articulating alternatives might be. Using the case studies, Moser traced enactments of disability that 'slip and move between multiple modes of ordering that co-exist, are partially related in complex ways, and even folded into each other' (p. 667). Case studies are therefore a recognised method within STS studies of clinical and therapeutic practices.

Case studies have also been used in sociological and anthropological studies using what Burawoy (1991) called the 'extended case method'. In distinguishing the extended case method from more traditional grounded-theory style sociological analysis—the latter is compatible with what I defined in Chapter 2 as social constructionism—Burawoy deployed the metaphors of 'generic' and 'genetic' analyses (p. 281). In describing the former type, he stated:

In the generic mode we seek out what different situations have in common, and generalization is based on the likelihood that all similar situations have similar attributes. Here significance refers to *statistical significance*, generalizations from a sample to a population.

(Burawoy, 1991 p. 281)

Generic analyses move across multiple situations in order to develop propositions whose significance lies in their being representative of the broader category of such



cases. In contrast, the significance of extended analyses of single cases is *genetic*. Burawoy (1991) explained:

In the genetic mode the significance of a case relates to what it tells us about the world in which it is embedded ... The importance of the single case lies in what it tells us about society as a whole rather than about the population of similar cases. (p. 281)

For Burawoy then, a single case may be used to evoke not just a broader category of cases, but the ‘society as a whole’. This is because that case has encoded within it practices and logics that operate at a much broader scale, in the same way that a gene found in any part of a body may also be found in any other part of that body. While the claim of my STS-informed case analysis is more modest—illuminating the modes of ordering specific phenomena within a specific discursive field, rather than ‘society as a whole’—the ‘genetic’ rationale is shared by STS analyses and extended case studies. Since many of the modes of ordering are widely deployed in Australia and elsewhere in the global ‘North’—in the form of assessment protocols, diagnostic criteria and disciplinary demarcations, for example—the single case study shares a similar ‘genetic’ code to clinical enactments of AOD use more broadly. Inevitably, some specificities will vary from site to site, but since all enactments are partial, truncated and contingent, I could not aim to fully translate my observations from the specific to general in any case. In these ways I present my case study of clinical science as having significance beyond its unique circumstances, but without claiming universality.

The second question begged by my case study method concerns the selection of the individual clinical patient, and the significance of this case in relation to broader populations. My answer to this question employs a ‘generic’ rather than ‘genetic’ analytic significance. In keeping with the aims of this thesis, and the role of this section within it, my criteria for case selection were that it be relevant for three populations of young adults: those who are heavy sessional drinkers; those who are engaged with clinical AOD treatment; and those who use AOD and are in disadvantaged life circumstances. It was to be most relevant for young adults who fit

into all three of these categories. In using these criteria to select the case from the sample, disadvantage did not limit the options much, as most clients whose clinical reviews I observed had some combination of housing problems, unemployment, mental health concerns, family and intimate partner conflict, and legal proceedings. However, of the 34 clients whose clinical review I observed, only four were aged between 18 and 25 years and had their alcohol use mentioned as a matter of clinical concern. Of these cases, the case I have selected for analysis was the most relevant because his alcohol use was the most unequivocally 'heavy' and 'sessional'.

According to Gomm, Hammersley and Foster (2009), 'it is necessary to compare the characteristics of the cases being studied with the available information about the population to which generalization is intended' (p. 105) and 'to consider the relevant respects in which the target population might be heterogeneous' (p. 105). In line with these epistemological principles, throughout the case study I make comparisons with the characteristics of the broader sample from which the case was drawn, and with relevant broader populations. I also amplify the relatively brief details available from the clinical review by making inferences from the broader dataset about the case study client's experiences within the withdrawal unit.

Nevertheless, I note Gomm, Hammersley and Foster's (2009) point that 'to the extent that there is substantial heterogeneity in the target population, no case within it preserves all the features of the whole' (p. 108). In this respect, I recognise that the particular confluence of specificities identified in the case study are unique and do not translate wholly to any broader population. For this reason, I frame the discussion and conclusions in broad and abstract terms that do not rely on the details of the case study so much as they rely on data from the wider sample and from literature concerning the broader populations of relevance.

Except for the removal of some identifying details, and the addition of some contextual details in square brackets, the text below is reproduced directly from the handwritten notes I made during the clinical review meeting.

24-year-old male inpatient for alcohol withdrawal. He blew .00 [BAC] at 9:15am. He drinks 2 to 3 days per week, usually 2–3 litres of wine. He completed a withdrawal in 2009. He attended [organisation name], an evangelical rehab program, after which he was sober for two months. He presented with cuts on arms and knees from falls and scuffles. He was hospitalised in 2012 after taking 30+ Panadols [a common brand of paracetamol] with alcohol. He presented to the clinician in a low mood. He takes Lexapro [escitalopram, a selective serotonin reuptake inhibitor]—10mg daily, and Champix [varenicline, a drug used to quit smoking], but he's taking both inconsistently. He is not prescribed Lexapro but he is prescribed Champix. He has regular contact with a psychologist and social workers, including at [a youth mental health service]. He has suicidal ideation but no plans. He is not welcome at home and his mother has taken a restraining order against him after episodes of violence. He is not working at the moment and is socially isolated. He was employed at [a supermarket chain] for a while, which was good for him. He is presently working towards getting his forklift license. Charges are pending against him for being drunk in public, resisting arrest and breaching an intervention order. He's not in the [NSAODC] catchment for counselling, but it is recommended that he get counselling and a referral is to be offered. A staff doctor will review him before entering the residential program. Who is his GP [general practitioner]?

I'll call the case study client 'Joshua'. Throughout the following sections of this and the following chapter, each sentence of these notes, and the terms and topics they record, will be analysed to reveal the modes of ordering problematic AOD use in general and young adults' heavy sessional drinking in particular.

### **Primary drug and other drug use**

The first sentence of my notes from Joshua's clinical review is: '24-year-old male inpatient for alcohol withdrawal.' In stating that Joshua was receiving treatment for alcohol, the clinician was indicating that alcohol had been designated as his 'primary

drug'. Other drugs were mentioned during the clinical review too. The ninth and tenth sentences of Joshua's clinical review are:

He takes Lexapro—10mg daily, and Champix, but he's taking both inconsistently. He is not prescribed Lexapro but he is prescribed Champix.

This section traces the enactment of alcohol as Joshua's 'primary drug' in the context of this other drug use. I will argue that disciplinary demarcations between medical and AOD clinicians play an important role in these processes, and in the attribution of causal roles to substances. Sentence 19 of the clinical review states that: 'A staff doctor will review him before entering the residential program', and the final (20<sup>th</sup>) sentence of the case review: 'Who is his GP?' indicates that AOD clinicians and medical practitioners sometimes interact to co-produce enactments of their mutual clients' AOD use. Medical doctors were present in a small minority of the clinical reviews I observed. In their absence, AOD clinicians focus upon drugs typically regarded as dependence-forming, and typically avoid attributing agency to other drugs. This means that drugs associated with dependence are readily associated with malign agency, while drugs not typically associated with dependence tend not to be assigned with agency in adverse events and life circumstances. These attributions mean that opportunities for interventions are missed and that drugs enacted as dependence-forming are problematised, while drugs not enacted as dependence-forming are not.

The primary drug is designated in the assessment process and involves clinicians asking clients about their use of different drugs and tabulating the responses. In a table on the intake assessment form, columns are given for 'tobacco products', 'alcohol', 'cannabis', 'sedatives (Diazepam, Xanax, etc.)', 'opioids (morphine, heroin, codeine)', and 'methamphetamine (speed)/ice, crystal meth'. For each of these columns, clients are asked a list of questions: 'name drug used', 'ever tried', 'age first use', 'age first regular use', 'route of use', 'average daily use: grams, no of IV hits, money', 'days used in last seven', 'in last 28', 'last use', and 'typical use last 90 days eg [sic] none, once, weekly, monthly'. After completing the table, the

clinician-client team are asked to ‘rank if possible’ each drug type according to a hierarchy of ‘most problematic’.

Two accounts of the designation of ‘most problematic’ or ‘primary drug’ were evident in the interview data. During the interview with Wal, I attempted to summarise his point about eligibility for the service when I stated: ‘to qualify for your services you, you just need to identify one [drug] that you clearly would go through withdrawal without.’ Wal replied: ‘that’s the one we would call it yeah the primary drug’. Wal suggests here that the drug without which a client would experience ‘withdrawal’ was the ‘primary drug’. On the other hand, William was telling me about one of his clients when he said: ‘there is a lot of illicit drug use as well, but I think alcohol was the primary one for him.’ I asked William to elaborate ‘about this distinction between the primary and the other things [drugs] that might be going on’. William replied that for this particular case, ‘alcohol was what got him into the immediate problems’. He continued:

So got him into trouble with, first, when he was drink-driving, which is highly dangerous and he had significant—he has had physical injuries and a neck and brain injury from the crash. Alcohol was the one causing the most immediate problems for him. Continued legal issues were then what got him involved into the forensic system, possibly even incarcerated and that would then create a whole new level of issues to go on with.

William suggests here that despite the client’s other drug use, the accident—and the imputed agency of alcohol in that event—had resulted in the physical injuries, legal proceedings and subsequently, AOD treatment. As such, alcohol was enacted as this client’s ‘primary drug’. This suggests that the drug attributed with effecting ‘the most immediate problems’, as opposed to withdrawal, can suffice for the enactment of a ‘primary drug’. In light of Joshua’s drinking ‘2 or 3’ days per week, and the questions this raises around withdrawal, I inferred that this was the case for Joshua’s clinical review.

Lexapro (escitalopram) is a selective serotonin reuptake inhibitor (SSRI), which is a family of antidepressants (Puri, 2013). As we will see in the *Mental health* section of the following chapter, clients at the NSAODC have often been diagnosed with mental illnesses such as depression. SSRI medications have been noted in some medical literature as potentially dangerous medications. In *Drugs in Psychiatry*, Puri (2013) stated that there is:

a risk of suicidal and perhaps even homicidal thoughts in patients who receive SSRI medication; this risk appears to be increased when there is a change in dosage of the SSRI ... All patients being treated with SSRIs and SSRI-like antidepressants should be regularly checked for evidence of: hostility; self-harm; [and] suicidal behaviour. (p. 171)

This excerpt shows that Joshua's use of an 'inconsistent' dosage of escitalopram might be enacted as causally linked with his 'episodes of violence', and 'resisting arrest and breaching an intervention order'. Such an enactment would complicate the designation of alcohol as Joshua's 'primary drug'.

Champix (varenicline) is prescribed to assist the cessation of tobacco smoking. Varenicline has been associated with 'neuropsychiatric events such as depressed mood, agitation, changes in behaviour, suicidal ideation and suicide' (Jiménez-Ruiz, Berlin & Hering, 2009 pp. 1319–320) and there have been case reports of exacerbation of existing psychiatric disorders in patients taking varenicline for smoking cessation (Jiménez-Ruiz et al., 2009 p. 1335). One study reported the case of a patient with a history of alcohol abuse and major depression who developed neuropsychiatric symptoms after initiation of varenicline (Pirmoradi, Roshan & Nadeem, 2008). Hence, as with escitalopram, there are grounds to enact varenicline as a causal agent in Joshua's 'episodes of violence', and 'resisting arrest and breaching an intervention order'. While no specific causal attributions were made during the clinical review, the designation of alcohol as Joshua's 'primary drug'—and the primary drug's association with 'the most immediate problems'—suggests that alcohol was assigned a closer causal link with these incidents than escitalopram

or varenicline. To establish how these different enactments emerge, I now consider some of the data collected on prescription drug use among clients of the NSAODC.

In the data from the interviews, clinicians demonstrated a particular concern for prescription drugs associated with dependence. Violet told me that ‘a lot of people come in with addictions, or dependence I should say, with medications as well’. This observation is consistent with the presence of prescription drugs on the intake assessment table listing potential ‘primary drugs’ of concern. Clients’ use of prescription drugs—including some not typically regarded as dependence-forming—was mentioned in all but a few of the clinical reviews I observed. Eighteen of 34 clients were taking some prescription drug mentioned in clinical review, and most other clients had some element of their psychoactive prescription history mentioned but were not taking medication at the time. Clinical concern about this drug use was expressed in cases in which two criteria were met. First, the drugs must be represented on the intake assessment table as a potential ‘primary drug’. Second they must be used in the absence of diligent clinical oversight: having a prescription written by an authorised medical practitioner is not enough, as some were deemed to be problematic prescribers. One case appeared to be an exception: concern was expressed in relation to an interaction with a drug on the intake assessment table, so in this sense, it too fell within the realm of legitimate concern for an AOD counsellor. There is a clear jurisdictional alignment of concern: AOD clinicians have an expert overview of drugs on the intake assessment table, but they yield to medical practitioners where other drugs are concerned. Drugs on the assessment table are enacted there, and elsewhere, as potential drugs of dependence, and as Violet indicated, drug dependence is the primary concern of AOD clinicians at the NSAODC.

These jurisdictional demarcations play a role in attributing responsibility for particular effects to particular drugs. My field notes from NSAODC suggest that the clinicians readily deployed causal enactments of methamphetamine: in one clinical review case, a clinician observed that: ‘A large percentage of ice users are developing psychosis. He looked at me suspiciously’. In another clinical review of an ice user, the presenting clinician stated that: ‘the [client’s] psychotic symptoms are

definitely [methamphetamine] dose related'. A further clinical review stated: 'His depression is related to [methamphetamine] withdrawal'. In the *Therapeutic jurisprudence* section in the following chapter, we will see that alcohol is often enacted as a cause of violence and offending behaviour. There are, however, no examples of violence or psychosis being attributed to prescription drugs other than those on the intake assessment table within the data collected.

Designations of alcohol as a primary drug enabled Wal to tell me that alcohol use was the primary drug for 'at least fifty per cent' of all NSAODC's clients. At the state scale, the practice of identifying a primary drug enables the production of statistical aggregations from the Alcohol and Other Drug Treatment Services National Minimum Dataset, which in turn enables statements such as: across Victoria in 2009–10, alcohol was the most common 'principal drug of concern' for which treatment was sought, accounting for 46% of closed treatment episodes (Australian Institute of Health and Welfare, 2011a p. 100).

In these processes, opportunities for interventions are missed. By attributing a causal role to escitalopram or varenicline, clinicians may have intervened to alter Joshua's use of those drugs. Restricting causal attributions to those drugs listed on the assessment table contributes to enactments of those drugs as problematic, and further stigmatises those who use them. It also reinforces enactments of drugs such as escitalopram and varenicline as therapeutic rather than malign, and protects those who produce, distribute and consume them from being associated with adverse outcomes.

## **Dosage**

The second and third sentences of my notes from Joshua's clinical review read: 'He blew .00 at 9:15am. He drinks 2 to 3 days per week, usually 2–3 litres of wine.' This section considers the enactments of dosage at the clinic, and the implications for understandings of alcohol's agency expressed in these statements. It identifies tensions between simple enactments of dosage as a function of a stable and singular pharmacological entity and complex enactments of alcohol effects mediated by poly-drug use, personal skill and variable tolerance. I demonstrate that while clinicians sense a futility in enacting the former, and intuit harm reduction potential in the



latter, simple realities prove more obdurate in the clinical context because they are performed by clinical science.

Clients' dosage and frequency of consumption were consistently discussed in the clinical reviews I observed and were usually inscribed using the assessment tool detailed in the *Primary drug* section above. Usually the dosage was expressed as a quantity of a specific product appended by fractional expressions of days per week and days per month. One example is 'half a cask of wine plus beer, 7/7, 28/28'. In addition to these measures, clients treated for alcohol use usually gave a breath test BAC reading at the intake assessment. Other clients did not have their drinking expressed like this because their reported levels of consumption were deemed unreliable. During one clinical review of a 51-year-old female client, for example, the clinician said: 'She's minimising her reports, and blew .106 [BAC] at ten-thirty in the morning. She said she'd had nothing today'. Other than this information, the clinician made no further statements about this client's level of consumption, presumably because what she had been told was deemed unreliable. Joshua's breath test data (.00 at 9:15am) corresponded with the account of his consumption, so his report was deemed reliable and was therefore included in the clinical review.

'Poly-drug use' is the norm among NSAODC clients, complicating enactments of dosage. Of the 17 clients whose alcohol use was mentioned in clinical reviews I observed, 11 had other drug use mentioned as well. In these cases, dosages of drugs other than alcohol are expressed in terms of their frequency and quantity, for example, 'ice ... 2-4 points two times per week'. In cases in which AOD dosages are considered, clinicians' primary concern is to gauge risk of overdose before or after treatment. Those assessed as having little overdose risk are eligible for withdrawal treatment, but those who use greater quantities more frequently, and particularly those who use opiates, tend to be offered counselling instead, to avoid the possibility of withdrawal leading to later overdose. In some cases alcohol clients use prescription medication outside of medical guidelines, or the medical oversight of their prescription medication is deemed to be problematic. These cases are designated as 'medically complex' and medical advice is sought for appropriate prescription regimes during withdrawal.

Here are some methods of inscribing alcohol dosage: client reports, BAC breath-testing, and poly-drug use that may be medically complex or present an overdose risk. These modes of enacting dosage interact in complex ways and serve to inform decisions about treatment and client safety. A significant point to note in these enactments is the absence of standard drinks as an enactment of alcohol dosage. Enacting alcohol quantities in standard drink units has, since the 1990s, become ‘*the* accepted standardized method for measuring individual consumption and assessing problematic drinking’ (Jayne, Valentine & Holloway, 2011 p. 830).

While this method was not used in clinical review contexts, standard drinks were enacted during a counselling and harm reduction group session I observed in the withdrawal unit. It is likely that Joshua would have encountered this mode of ordering alcohol dosage during his stay there. According to the printed materials provided to clients<sup>11</sup>, a standard drink contains 10 grams of pure alcohol, and varies in volume according to the product. For example, an (unreferenced) table informs us that 30ml of spirits/liquors constitutes a standard drink, and so does 425ml of light beer. Quantities of ‘low risk’ drinking for men and women are given in an adjacent table.

Information on standard drinks and the NHMRC alcohol guidelines were also available in a pamphlet entitled ‘The facts about alcohol’, which was published by the NSAODC and freely available in the waiting room clients used before their appointments. In the counselling and harm reduction group session I observed, upon receiving this printed material, one female client responded, ‘that’s bullshit. Why is there a difference between males and females here? I can drink and smoke more than all my male friends.’ Here this young woman challenges the deployment of gender in the guidelines, and the failure to account for the simultaneous use of other drugs during drinking sessions which, she implies, is common practice among her peers. Her assertion that she can drink and smoke more than all her male friends also

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<sup>11</sup> A citation for this document, and for other in-house publications of the NSAODC, are not provided for two reasons. First is to ensure the anonymity of the service, and second; because these documents are treated here as ethnographic data rather than as literature.

implies that consuming quantities of intoxicants is a skill or capacity possessed by an individual, and that this skill or capacity mediates the effects of a given pharmacological dosage. The young woman's enactment of a complex, situated account of alcohol dosage and its effects undermine the relevance of the guidelines' simple, aggregated enactment.

Another complex, situated enactment of dosage was evident in a conversation I had with a young man in the withdrawal clinic. My notes record:

Last time he left detox he got home, had two cans and two bongs [a water pipe for smoking marijuana] and he was on his arse [very intoxicated]. Usually it's ten cans, ten Xanax [a benzodiazepine product] and ten bongs.

Here the client articulates a variable relationship between a subjective experience, being 'on his arse', and a dosage of alcohol, cannabis, benzodiazepines, and perhaps tobacco. I infer from this example that the client made sense of the change in his subjective experience as an effect of his lowered tolerance after being without AOD while in the withdrawal service.

Complex, situated enactments of dosage were evident in other clinical contexts. For example, William explained one enactment of dosage that was used in a counselling session:

[the client] was regularly binge drinking out with friends; and so one thing that actually came out within sessions was recognising what he's like at different stages of intoxication, and what his ideal stage is he wants to head towards. No, I hadn't done this with a client before. It just came up that he saw like in his tipsy self, his sober self, he saw that as a bit boring, and felt he needed alcohol to have that, to be able to sort of open up to the group or to fully relax. Then the tipsy him was, kind of, ah, you know, he had a few, kind of, more relaxed but he liked that one. We then had three more stages, I can't quite recall what

they were, but essentially they were tips—yes, it was sober, relaxed, tipsy, drunk, and then blind drunk. And recognising how he began to escalate, as the night went on, he'd try and zip through and try to get to tipsy or sometimes drunk, but generally he'd overshoot and go to blind drunk. So it was thinking how we might be able to slow that down and recognise what he can enjoy from each different stage.

Here, William explained that, in his discussions with this client, he identified a loose, progressive typology of intoxicated states used by the client; tipsy, drunk, drunk, and blind drunk. Borlagdan et al. (2010 p. 48) and de Crespigny (1999 p. 447) noted that typologies such as this are prevalent among young adult drinkers. These enactments are grounded in the client's subjective experience of intoxication, rather than a standardised measurement of a pharmacological agent's effects. Rather than impose a stable pharmacological enactment, William instead worked within the client's own typology of subjective states of intoxication. This mode of enacting dosage was not something William had used before; it arose inductively from his discussion with the client. The novelty of this approach might be explained with reference to the NHMRC guidelines, and their enactment of standard drinks and safe dosage, printed on the pamphlet in the waiting room. It seems William was negotiating a tension between aggregated and situated enactments of alcohol dosage.

Wal also experienced tensions between different enactments of dosage. He explained that in his counselling sessions with drinkers: 'we use harm reduction strategies, you know NHMRC recommended drinking levels, you know, what makes a standard drink'. He told me that he was doubtful that the harm reduction alcohol information he disseminated among his clients was effective:

People are impulsive and they get carried away and split over what their friends are doing, and whether the session you had with them a week or a month or so ago will change their behaviour and stop them from picking up the fourth or fifth drink or whatever, and then the way they behave once they are intoxicated, I just don't, I'm not so convinced that it would.

Here Wal demonstrates a sensitivity to the complex forces driving consumption in drinking events, including ‘what their friends are doing’. His sense is that the enactments in the NHMRC guidelines lack agency among the throng of other forces. Some research has been critical of the guidelines for failing to acknowledge the complex contextual considerations young drinkers employ to assess the quantity of their drinking and the structural exclusion of pleasure, sociality and other kinds of value young people attribute to drinking (e.g. Harrison et al., 2011; Lindsay, 2010). Qualitative and quantitative research has also reported that the 2009 NHMRC alcohol guidelines have little traction with young drinkers (Harrison et al., 2011; Michael Livingston, 2012a). Wal’s scepticism about the utility of providing harm reduction education suggests that he also perceives a tension between the simplistic enactments of the guidelines and the complexity he encounters when considering his clients’ drinking events. During the interview, I asked Wal what research topics or questions might be useful for assisting his clinical work. He answered:

I’d like to know the impact that harm reduction education has. It seems like a logical thing to do and everyone is always talking about education as being the key ... but I haven’t seen that much that talks about the effect of it.

It seems that Wal would prefer not to have to go through the motions of harm reduction education using standardised enactments of dosage, but he feels that he lacks the scientific reference points for making such a departure from what is currently ‘the logical thing to do’.

Returning now to Joshua, we can observe that, in his clinical review, his AOD dosage was constructed in terms that assessed his reliability as an informant, and his risks of a ‘medically complex’ withdrawal and overdose after leaving the clinic. During his time in the withdrawal clinic Joshua was probably presented with harm reduction information that constructed his alcohol dosage as a measurement of standard drinks. This is likely to have jarred with his own situated modes of ordering dosage, which accounted for poly-drug use, personal skill and variable tolerance, and

followed a progressive typology of intoxicated states. It is possible that during counselling sessions clinicians assisted Joshua to articulate his alcohol dosage in these terms, but it is more likely that they reluctantly provided him with the standardised harm unit-based information, because it was ‘the logical thing to do’.

## **Conclusion**

In this chapter, I have used an extended case method and techniques drawn from STS to detail enactments of alcohol and other drugs in the context of an AOD clinic treating young adults in Broadmeadows, among other client groups. I have argued that situated accounts of causation in alcohol-related circumstances can yield opportunities for reducing harm among those receiving treatment.

In clinical review contexts, alcohol dosage is enacted through complex interactions between client reports, BAC testing and poly-drug use. These enactments inform decisions about treatment recommendations and client safety. In treatment contexts, standard drink enactments of dosage perform alcohol as a stable and singular pharmacological entity. Because these simplistic enactments of alcohol dosage are scientifically performed, they are granted a status as ‘logical’. Clients resist these simplistic enactments and prefer situated enactments accounting for subjective states, poly-drug use, personal skill and variable tolerance. Sometimes clients employ progressive typologies of intoxicated states that are grounded in their personal and situated sensitivities. Clinicians intuit that deploying these enactments in their discussions with clients has the potential to assist clients to achieve a desired threshold of intoxication, and minimise harms. With some exceptions, clinicians do not deploy these situated enactments because they are not supported by a scientific base, and the potential for harm reduction is foregone.

Enactments of alcohol as a primary drug are sometimes justified by its attribution as a causal agent in the most immediate problems in clients’ lives. These attributions are made possible by clinicians’ sensitivity to the agency of drugs associated with dependence and listed on an intake assessment table. Other sensitivities may have made other attributions possible. In Joshua’s case, a sensitivity to the agency of escitalopram and varenicline may have enabled these drugs to have been attributed

with at least some causal role in his life circumstances. Such an attribution may have been to Joshua's benefit, in that it may have motivated changes to Joshua's use of these drugs, and altered their agential force in his life. Jurisdictional demarcations between AOD and medical clinicians ensure that these attributions were not made and that causation was more readily attributed to alcohol. These jurisdictional demarcations were co-produced by the intake assessment table, which, like standard drinks, are a production of clinical science.

Clinical instruments such as tables enacting standard drinks and 'primary drugs' of concern reinforce enactments of alcohol as malign, and stigmatise heavy sessional drinkers as irrational. They de-emphasise the role of complex contextual factors such as the agency of other drugs, variable tolerance and subjective experiences of intoxication. Insofar as they act in these ways, they reduce the harm reduction potential of AOD treatment.

In this chapter I analysed seven sentences of a clinical review case study for their enactments of AOD. In the next chapter, the remaining 13 sentences of the clinical review will be analysed for their enactment of Joshua as a clinical subject, that is, as a problematic AOD user.

## Chapter 9

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# Enactments of clients in a clinical AOD treatment setting

As in the previous chapter, in this chapter I use an extended case method and techniques from STS to detail enactments of clients and their life circumstances at the NSAODC. I further develop the case study of Joshua's clinical review and argue that the enactment of clients with a broad range of AOD use practices as 'dependent' foregrounds AOD use as the force to which life problems might be attributed, backgrounds other forces and depoliticises them, and stigmatises clients by rendering them pathological. I contend that these processes of foregrounding, backgrounding and stigmatising are political moves. In the course of making this argument, in this chapter I detail enactments of young adult clients; abuse, dependence and withdrawal; mental health; accommodation and employment; therapeutic jurisprudence; and multiple treatment episodes.

### Young adult alcohol clients

The first sentence of Joshua's clinical review reads: '24-year-old male inpatient for alcohol withdrawal.' According to the NSAODC staff I interviewed, Joshua is much younger than most clients treated for 'alcohol problems', although heavy drinking is not unusual among young adults. The circumstances in which young adults are enacted as problem drinkers are the subject of this section. I argue that it is primarily socioeconomic disadvantage and other problematic life circumstances such as legal entanglements that qualify young adult drinkers as needing treatment.

In our interview, Reginald, whose role at the NSAODC involves designing, testing and seeking funding support for service models, said binge drinking was 'just the standard shit that high school kids do', and in that sense, it was not typically a matter



for clinical concern. Reginald told me that most people who sought assistance to change their drinking were in their forties. He explained:

they're old enough to be starting to experience some of the physical and the health consequences ... they're quite potentially parents by this stage ... and they're starting to recognize the impacts of their behaviour on the children. And they're just realising that, "I can't keep doing what I've been doing for the last twenty years anymore" ... that's the moment where change is really possible ... younger people that haven't hit that stage ... they haven't had to confront direct and ongoing consequences ... [they are] still young and bulletproof and worrying about this stuff is for older people.

It is important to note that Reginald was not suggesting here that young adults do not drink; rather they tend not to worry 'about this stuff'. Violet concurred with Reginald's sense that younger drinkers tend not to seek treatment for their drinking. In her work with young (voluntary) clients in Broadmeadows, she had 'never had anyone come to me in Broadmeadows for alcohol use'. The clients Violet works with most frequently are those who have:

probably been drunk when they're younger and cannabis has ended up being their drug of choice and they've ended up, or yeah they've progressed to ice use at, yeah maybe eighteen, nineteen or so and then it's been a few years of doing that and then they've gotten to the point where they want to, you know, things aren't going so great for them.

That alcohol is not regularly designated as the 'drug of choice' for young clients does not indicate that clients don't drink heavily from time to time. Violet said that:

it's not that they're not drinking, it's not that they're not bingeing but they're just not identifying it as a problem ... clients don't bring alcohol generally to our sessions ... they don't talk about it.

Violet and Reginald were of the view that young adults tended to drink heavily from time to time, but not to seek treatment for their alcohol use. They suggest that heavy sessional drinking among young adults is normalised and taken for granted. Of the 34 clients whose clinical review I observed, 12 clients were aged between 18 and 25 years. Other than Joshua, two of these were in treatment for alcohol. One was facing legal charges at the time of his service access, and, as I will show in the *Therapeutic jurisprudence* section later in this chapter, his clinical AOD treatment cannot be understood in isolation from his legal entanglements. The other sampled client in treatment for alcohol, who was a withdrawal service inpatient, had been ‘born into DHS [Department of Human Services] care’ and was ‘used to this kind of environment’. Prior to entering the withdrawal service he had been living in a boarding house, and had established a ‘patchy service history. Turning up in crisis, asking for medication for anxiety.’ He had taken a daily dose of anxiolytics during his stay. Each of the sampled young adults in treatment for alcohol use had significant life problems in addition to their drinking, and their accessing of treatment cannot be understood without reference to these life problems.

Reginald told me that clients were sometimes referred to the NSAODC because other service agencies were finding them difficult to handle:

we’re just getting agencies just handballing people to us ... this person’s got a, you know, got a diagnosis of um, personality disorder or whatever, they’re too difficult to work with so we’re not going to touch them ... “go and sort your substance use out and then come back and see us” ... You know, we, we get you know, I think for a long time we’ve been recognised as, “If you can’t get anywhere else you can always get in here.”

In the context of interactions such as this, Reginald said that the NSAODC worked with other social service agencies:

just to develop the understanding that like the key issue for this kid isn’t their cannabis use or isn’t their amphetamine use, it’s the sexual

abuse they experienced when they were this age or the fact that they're homeless or whatever else is in their history.

'The key issue' for some NSAODC clients is not AOD use at all, but as we will see in the *Abuse, dependence and withdrawal* section below, this does not hinder their enactment as problematic AOD users. I asked Reginald why it was that despite these client needs, NSAODC still positioned itself as a specialist AOD agency, rather than an agency providing assistance with a broader range of service needs.

I mean partly it's historical ... partly it's because their, all their funding is through drug and alcohol funding ... I think it's probably not a question that we've asked ourselves, we've just carried with momentum you know for the last forty years ... I guess if, if we had to sit down and come up with a rationale for whether or not we wanted to remain purely as... a drug and alcohol-branded organisation, I imagine what we would probably say would be that there's still a clear need for ... retaining a specialist expertise in that field ... but also to be able to increase the... wider workforce development and put sort of sectoral awareness of the issues that are relating to these clients.

In this reply, Reginald does not justify his organisation's focus on AOD treatment with reference to its clients' needs. Rather, its history and role in 'the sector' form the primary justification for its specialist role. This orientation has significant effects upon the NSAODC's clients and upon enactments of the drugs they use. Some of these effects will be identified in the remainder of this chapter.

In light of these data, I observe that Joshua's enactment as a problematic heavy sessional drinker is made possible by his alcohol use in the context of broader disadvantage and problematic life circumstances. While staff at the clinic recognise that this is the case, their treatment focus is on Joshua's drinking rather than his other life circumstances. They sustain this focus because of their organisational history and role within the broader welfare sector, rather than because it is what Joshua's needs most to improve his circumstances.

## **Abuse, dependence and withdrawal**

That Joshua drinks two to three days per week and is an inpatient for withdrawal raises some questions around enactments of bingeing, dependence and withdrawal. In this section I consider some of these issues and their significance to Joshua's clinical review, particularly to his enactment as a problematic drinker. I demonstrate that clinicians are motivated by humanitarian values to take a broad view of dependence, but that this can have politically disempowering effects for clients.

Within the context of the NSAODC, one common mode of ordering withdrawal is as a medical condition experienced by clients who are dependent on a substance and who have recently ceased to use that substance. Withdrawal syndrome is defined as the presence of physical or psychological symptoms in the absence of the substance. Symptoms are understood to vary from substance to substance. For instance, I observed a clinician telling a young man in a withdrawal service that 'withdrawal from alcohol is shakes, sweat from cannabis, fits from Xanax.' Withdrawal from alcohol, and signs of dependence upon it, can be enacted by a clinician observing a client's body shaking in its absence. However, another condition for dependence in Wal's account was daily use. Wal, a nurse specialising in treating withdrawal, told me that he used the *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition* (DSM-IV)<sup>12</sup> (American Psychiatric Association, 2000) to distinguish between clients who were 'dependent' and those who 'abuse' alcohol.

So the DSM-IV defines alcohol dependence and alcohol abuse. I use the DSM-IV criteria for alcohol abuse for binge drinking, so it's not daily. With a physical dependence, as opposed to abuse, which does have a, a uh, physical dependence that manifests itself in a withdrawal syndrome if they cease, so someone who is dependent is more requiring of a physical, a physical, medical withdrawal, than somebody who's binge drinking ... that's the difference so if someone

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<sup>12</sup> The DSM-IV was current at the time these data were gathered. The DSM-5 was published in May 2013.

was likely to go through withdrawal when they stopped, you'd define them as an alcoholic um, dependent rather than a binge drinker.

Here, Wal uses withdrawal and daily use to distinguish between dependence and abuse. Joshua did not use alcohol daily. At two to three days per week, the frequency of his heavy drinking seems to accord more with 'abuse' than 'dependence'. I infer that Wal did not expect that this patient would experience withdrawal syndrome, and yet he was being treated in an inpatient withdrawal clinic. According to Violet, it is possible that some people who do not drink or use drugs daily may still 'possibly' be considered dependent. She outlined an example of a marginal case:

...a lot of people will say in assessments, I'd be drinking every day, or I'd be using every day if I had the money for it. But they're not committing crimes and they're just using their dole money or whatever to use it and then they run out and then "I scurry [move quickly and dodge threats] for the next four days". So someone like in that position could possibly still be considered dependent. So I don't know, it's a difficult one.

Here, Violet did not reference a particular disciplinary context for such an assessment; she was, presumably, talking about processes for enacting the threshold of dependence in the NSAODC. In that context, people might go 'four days' without drinking and still be considered dependent. There are other marginal cases too. A good proportion of the agency's withdrawal clients identified their primary substance as 'ice' (crystal methamphetamine). I learned that there was some controversy as to whether or not ice users were dependent in the DSM-IV sense. Violet told me that 'when you look at ice for example, like you tend to have a bingeing pattern as opposed to daily use.' She added: 'I'm hearing from management about other withdrawal units not accepting people who are using ice for example, because they don't think they need to do withdrawal for it.' This dynamic has, according to Violet, caused the waiting lists for the NSAODC withdrawal services to grow into 'the biggest I think I've ever seen.'

While there are some ambiguities around enactments of withdrawal, and interference from marginal cases, clinical review data suggest that the enactment of clients as dependent is not necessary for admission to withdrawal. Some withdrawal inpatients are well outside any enactment of dependence and are not in the clinic for the kind of withdrawal that Wal had explained. One inpatient whose case I saw reviewed was exclusively a cannabis user and she had been abstinent from cannabis for four months prior to entering the service. Instead, the clinicians indicated: ‘Her main motivation is to be DHS-free. Child protection have taken her daughter away before.’ Here, it is implied that the client’s cannabis problems arise not so much from cannabis use as from the perceptions of officials within a government department, and the NSAODC service is positioned more as a response to a bureaucratic, and subsequently familial circumstance than to the client’s drug-using practices. In addition, this client’s case review noted that: ‘we need to manage her mood. Five months ago she was cutting [self-harming] and suicidal’; ‘She has childhood trauma (sexual), and borderline personality disorder’; and ‘Her depression is stable’. Withdrawal treatment, or ‘detoxification’ as it is sometimes called, has long been recognised as having significance beyond the management of AOD use. In a review of issues concerning the treatment of young people with problematic AOD issues, Howard (1993) noted:

Detoxification for adolescents is not usually one [treatment] requiring medical intervention, as levels of drug use are mostly not as high as those of adults. However, adequate medical back-up is essential. The “detoxification” is normally from peers, the streets, toxic families, or other relationships. It provides a short time away from chemicals, in a safe place, where consideration of the impact of use, some education and increasing awareness of alternatives can occur. (p. 120)

In other words, AOD use is but one of a complex array of ‘toxic’ familial, social, affective and material circumstances that are recognised as legitimate reasons for young adults to access withdrawal treatment. A recent survey of 13–24-year-olds who had recently used AOD and who were clients of AOD or welfare agencies from across Melbourne (MacLean, Kutin, Best, Bruun, & Green, 2013) captured a range

of dimensions of their socioeconomic disadvantage and life problems. Around 30% were homeless, living in temporary accommodation or in foster or residential care. On average, they had attended over six different primary schools and secondary schools, while 83% said that they had been suspended from school or an educational program at some point. Approximately 80% of participants had served a community order and one-third had been incarcerated. Thirty-eight per cent had been diagnosed with a mental illness. While these figures are not necessarily representative of young adults at the NSAODC, or of young adult AOD users and clients more broadly, there is a clear indication that the co-occurrence of AOD use, clinical AOD involvement, socioeconomic disadvantage and life problems is the norm. The confluence of these elements is at the core of many enactments of dependence at the NSAODC, and this is most likely to have been the case for Joshua.

How might we characterise the deeper ideological and normative commitments at work in these enactments? Wal gave me some grounds for responding to this question when he said:

It's very, very seldom that we refuse anybody. I think that's ... from management. Management here are really humanistic and understanding and very supportive. It's [this ethos is] right through the place, it's great.

Wal suggests here that a 'humanistic' values system motivates the service to provide assistance to clients when they seek it, and that this system can override the DSM-IV system for enacting dependence and withdrawal syndrome.

This begs a further question: what does it mean to permit those 'dependent' on alcohol or other drugs to access 'withdrawal treatment'—one to two weeks of food, clinical care, shelter and a secure environment—when the other circumstances of clients' lives do not afford such access? Ticktin (2006) discussed 'the consequences of humanitarianism as politics' through analysis of a humanitarian clause in French immigration law, allowing undocumented immigrants suffering from a 'life threatening' illness to remain in France. While beneficiaries of the clause can avoid

deportation and access medical services, they are also effectively disqualified from 'taking any economic, social, or political role in French society'. We might observe that, in the NSAODC withdrawal service, clients who are enacted as suffering from AOD 'dependence' are given the benefit of 'treatment', but in being enacted as 'dependent', they inhabit a subjectivity that is pathological and stigmatised. It is evident from the dataset that the forces drawing young adult heavy sessional drinkers and other drug users into clinical AOD treatment usually extend well beyond AOD use and commonly include unemployment or unstable employment, contact with police and the justice system, unstable housing and social isolation. While these circumstances might be understood as political and structural—as effects of processes involving economics, law, citizenship, human rights, and the policies of the state—they are depoliticised in enactments of dependence because alcohol and other drugs, rather than citizen-state relations, are foregrounded as the primary causal agents in clients' life circumstances. In Ticktin's study, French medical officials were motivated by a humanitarian value base to take a broad view of what constitutes 'life threatening' for the purposes of activating the clause. Similarly, NSAODC clinicians take a broad view of what constitutes 'dependence', but in both cases attention is focused 'on what is construed as an apolitical, suffering body' (p. 39). Admitting the suffering body as having a valid claim upon humanitarian institutions, while denying the claims of humans constituted otherwise, that is, those who are poor, marginalised and excluded, has political effects with the result that 'the supposedly apolitical suffering body is becoming the most legitimate political vehicle in the fight for a broader concept of social justice' (Ticktin, 2006 p. 45). According to Ticktin (2006), the humanitarian impulse 'based on the universality of biological life' (p. 39), 'emphasises benevolence over justice, standards of charity over those of obligation' and 'ultimately protects and encourages a limited and limiting notion of humanity' (p. 42). Enactments of dependence then, while humanitarian, have politically disempowering effects for NSAODC clients: they foreground AOD use as the force to which life problems might be attributed, and they background other forces and depoliticise them.

In Joshua's case I infer that, while his housing, employment, family relations and legal circumstances have motivated a humanist response from NSAODC staff, and



gained him access to the material and other benefits of withdrawal treatment, these forces in his life have been relegated to the background, and his drinking has been brought into the foreground, through his enactment as a ‘dependent’ drinker.

## **Mental health**

Sentences seven and eight of Joshua’s clinical review refer to his mental health and degree of suicidality: ‘He was hospitalised in 2012 after taking 30+ Panadol with alcohol. He presented to the clinician in a low mood.’ Sentence 12 adds detail: ‘He has suicidal ideation but no plans.’ Sentence 18 specifies that Joshua will be referred to counselling: ‘He’s not in the [NSAODC] catchment for counselling, but it is recommended that he get counselling and a referral is to be offered.’ In this section I consider the modes of ordering ‘comorbid’ poor mental health and AOD use at NSAODC. I will argue that competing modes of ordering particular causal flows between poor mental health, troubled life circumstances and AOD use arise from a vested interest in enacting reality in one way or another. Discrete enactments of mental health and AOD use in models of dual diagnosis and comorbidity ensure that AOD problems remain attributable to pharmacological substances. More fluid enactments positioning substance use and poor mental health as symptomatic of emotional processes or problematic life circumstances focus attention on remedying those causes, but maintain the status of AOD use as problematic. In contrast, I detail an enactment by an NSAODC client which justifies alcohol use as a means of regulating his mood. This enactment challenges the other attributions and positions substance use as therapeutic.

Poor mental health was enacted in a significant proportion of the clinical reviews I observed: 14 of the 34 clients whose clinical review I observed scored above the threshold for ‘Considerable symptoms of depression, anxiety and/or somatic complaints’, as defined by the psychometric instrument used in the intake assessment, the PsyCheck Screening Tool. A user guide accompanying the tool states that it is used to make visible ‘the likely presence’ of ‘comorbid’ disorders.

NSAODC clinicians sometimes employ the notion of comorbidity, and Violet told me that all clinicians there are required to be ‘dual diagnosis [comorbidity]

competent'. The enactment of psychological distress and dysfunction that co-occurs with AOD use as comorbidity is in line with the American Psychiatric Association's classificatory system of 'substance use disorders' and various other 'mental disorders', the DSM, which, as I demonstrated, also played a role in enactments of dependence and withdrawal. Dual diagnosis programs within addiction treatment settings have become increasingly widespread in the sector since the early 1990s (Minkoff, 2008). The nosology of disease entities in the DSM has separate symptoms and defining criteria for discrete disorders. A clinician employing the DSM-IV to characterise Joshua's drinking habits, 'low mood' and 'suicidal ideation' might diagnose a comorbid combination of a depressive disorder and an alcohol abuse disorder. This mode of ordering has implications for the ways that alcohol use and other life circumstances are conceptualised and treated.

Criteria for the DSM-IV for 'alcohol abuse disorder' make reference to broader dimensions of AOD users' lives:

- [In the past year, have you] Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
  - [In the past year, have you] Continued to drink even though it was causing trouble with your family or friends?
  - [In the past year, have you] More than once gotten arrested, been held at a police station, or had other legal problems because of your drinking?
- (American Psychiatric Association, 2000)

In these criteria, problematic alcohol use is positioned as having a deleterious effect on a range of life domains. The causation flows in one direction, from pathological alcohol use to diminished life circumstances. As the causal agent, alcohol use is foregrounded as the *sine qua non* of clients' troubled life circumstances. This means, for example, that clients' problems with 'taking care of their family', and their 'job' or 'school' troubles are not attributed with agency in mediating the effects of AOD use. They are instead positioned as 'a backdrop or relay for the flows of causal efficacy' (Latour, 2005 p. 128).

This is a clinical mode of ordering Joshua's drinking and mental health problems, and along the way his broader life circumstances have been ordered too. These modes of ordering are held in place at the NSAODC by the PsyCheck Screening Tool and the DSM-IV. However, in previous sections I demonstrated that NSAODC clinicians sometimes resist the modes of ordering produced by abstract clinical science, and I will now consider the extent to which this is true of mental health 'comorbidities'.

William told me that he often works with the thoughts and feelings of clients:

our work doesn't just involve AOD for pure focus, it tends to have a lot of focus on emotional processing and regulation. That's—it covers many other areas, but I'll tell you that is probably the secondary area we focus on ... when someone can understand how they process emotions and manage them, understanding that can actually cause, lead to a reduction or even cessation of AOD use.

Here William performs a causal interaction of four entities—the client, 'many other areas', alcohol, and understandings of how to manage 'emotional processing and regulation'. The causal flow moves from the client being transformed by internalising the understandings of 'emotional processing and regulation'; thereby reducing their alcohol consumption and transforming their 'many other areas'. While this account proposes a more complex causal flow than the DSM-IV account, it stops short of an assemblage model, where alcohol effects can be transformed by the mediations of co-constituting entities. Such enactments are possible at the NSAODC, and such a case will be introduced later in this section.

With reference to her training as a social worker, Violet also enacted a fluid landscape in which AOD use, poor mental health, and troubled life circumstances causally interact in complex ways:

It's expected of us and, as social workers, this is what's drilled into us; you know you got to look at everything in the person's life. Yeah, definitely talk to people about their mental health. Talk about what's going on at home. Talk about, "do you want to go back and study or are you feeling in a better position to maybe look for work now" and, you know, always look at everything. It would be ridiculous not to. You can't, I mean drug use doesn't happen in a vacuum by itself, it's looking at the whole picture. It's essential.

Here Violet deploys a wide range of entities at work in shaping clients' mental health and AOD use circumstances; 'what's going on at home', study and work roles: 'everything in the person's life', 'the whole picture'. Despite this sensitivity to a wide array of forces, Violet's statement that 'drug use doesn't happen in a vacuum by itself' is an ambiguous causal assertion. Is it the *use* that is affected by a range of factors, or is it the *effects* of that use that are mediated by an assemblage of 'everything in the person's life'? Her claim is compatible with either reading, but she avoids making an unequivocal statement positioning AOD effects as fully mediated by life circumstances.

William and Violet both use the PsyCheck screening tool in their intake assessments, and the discrete enactments of mental disorders and substance use disorders therein. They also deploy causal models in which adverse life circumstances, including poor mental health, can be understood as causes of, rather than effects of, AOD use. Departing from the DSM enactment, Violet and William address their client's mental health as a means of addressing their substance use. To this extent, Violet and William contest the DSM's causal construction of AOD as the primary cause of poor mental health among their clients. However, by avoiding causal propositions in which substance effects, rather than substance use, are co-constituted by poor mental health, Violet and William fail to take the more radical step of constructing AOD use as only potentially, rather than necessarily, problematic within their clients' lives.

One enactment from the NSAODC that does make this leap is from a conversation I had with a male inpatient in the youth withdrawal unit. My field notes record the following:

He never leaves the house sober. When he's sober he gets angry—he might hit the phone out of someone's hand when he's walking past. He wouldn't do that after a drink. It makes him feel more relaxed.

In this account, the client's alcohol use plays a functional role to suppress his anger and to allow him to leave the house without damaging and transgressive outbursts. The client figures alcohol as a therapeutic agent soothing an angry disposition, and is transformed by alcohol as a 'relaxed' subject rather than an angry one. This account stands in contrast to the simple causal mechanism postulated in the DSM-IV, and the more fluid accounts of William and Violet. It positions alcohol as a solution, albeit a temporary one, to the client's problem of anger, rather than a cause of it.

Analysis in this section has shown that several enactments of causal flows between Joshua's 'low mood', potential suicidality and AOD use are possible at the NSAODC. First, they can be enacted discretely as comorbid disorders through the intake assessment process. Second, they can be treated by clinicians as symptoms arising from a misunderstanding of 'emotional processing and regulation' or of a 'whole picture' of the person's life. Third, a client can position alcohol as a therapeutic agent to treat his troubled state of mind. These different enactments represent more than shifts between disciplinary and vernacular vocabularies; they are freighted with political implications arising from opposing causal propositions. First, if substance use is the agent responsible for poor mental health, then ceasing or controlling substance use is the solution. Second, if substance use and poor mental health are symptomatic of a client's 'emotional processing and regulation' or the 'whole picture' of their life circumstances, then remedying those problems will enable the client to become mentally well and control or cease their substance use. Third, if a client's poor mental health and life circumstances can be remedied by alcohol use, then ceasing use will not improve his circumstances. The DSM, the clinicians and the client each have distinct agendas and construct their accounts of

the causal flows accordingly. The DSM-IV seeks a universally applicable, concrete diagnostic tool which is capable of making a single causal account of many possible scenarios, and in so doing, positions alcohol as the effective master agent. The clinicians seek to respond to the complexity of their clients' lives and to find ways to respond therapeutically, but continue to position AOD as the therapeutic target to maintain a sense of the relevance and utility of their role. The male inpatient in the youth withdrawal unit positions alcohol as an agent that, in his case, plays a therapeutic role in soothing anger. This enactment maintains a role for alcohol in his management of life circumstances, and moves the focus of the 'problem' towards his tendency towards anger. Each of these competing modes of ordering causal flows between poor mental health, troubled life circumstances and AOD use arise from a vested interest in enacting reality in one way or another.

In Joshua's case, we may speculate that the enactments of his 'low mood' and suicidality emerged differently in the explanations of clinical science, the clinicians and Joshua himself. As each enactment proceeded and controversies developed, deeper questions emerged about the nature of AOD use, mental health and disadvantage. While these questions were specific to Joshua's case, they can also be taken to evoke political contests at a much larger scale.

### **Accommodation and employment**

The statement in the 13<sup>th</sup> sentence of Joshua's clinical review gives evidence of his family circumstances: 'He is not welcome at home and his mother has taken a restraining order against him after episodes of violence.' Sentence 17 suggests that he had subsequently breached this, or possibly another intervention order: 'Charges are pending against him for being drunk in public, resisting arrest and breaching an intervention order.' No other residential arrangement is mentioned during the clinical review, so I infer that Joshua has a housing problem. Sentences 14, 15 and 16 of Joshua's clinical review read:

He is not working at the moment and is socially isolated. He was employed at [a supermarket chain] for a while, which was good for him. He is presently working towards getting his forklift license.

I infer from Joshua's case that clients' accommodation and employment circumstances are matters of clinical concern at the NSAODC. Clinicians' concern about accommodation and employment circumstances, their ability to respond, and their attributions of causal interactions with clients' AOD use and its effects are the concern of this section. I argue that clinicians understand clients' lack of housing and employment options as mediators of AOD use and harms, yet are unable to act upon these forces directly. Clients are enacted primarily as problematic AOD users rather than as products of housing or employment supply shortages, rendering their problems as personal rather than systemic.

On the intake assessment form, space is designated for clinicians to detail clients' accommodation status. Listed options include 'shelter/refuge', 'public place (homeless)', and 'boarding house/hostel'. There is also a field for clinicians to detail 'current stressors'; examples include 'accommodation difficulties' and 'drug-using cohabitants'. Unstable housing was common among the clients whose cases I saw reviewed and was attributed with a range of causal actions shaping clients' drug use. For example, one client lived in a boarding house that was known to clinicians as 'a hotspot for dealing and use ... he's at risk in that area.' Another client 'experiences domestic violence in her relationship. There is a current intervention order, but she is living with him. The partner gives her the substance.' In both these cases, the marginal accommodation circumstances of clients were enacted as causally related to their drug use, along with other issues.

Despite their mandate to assist AOD users to control their use, and the sometimes integral role attributed to accommodation, there was little clinicians were able to do to alter clients' accommodation arrangements other than making referrals to other services. Instead, they tried to tailor their interventions to best suit clients' living circumstances at the time. For example, clinicians were discussing the 'post-withdrawal plan' of a client who was to enter the withdrawal service. The client had been 'talking about [entering a rehabilitation service], but she's just got housing'. The clinicians agreed that entering rehabilitation would mean that the client would 'lose her housing', so 'pre-admission counselling to develop a post-withdrawal plan'

was the intervention they decided upon instead. In other cases, clients' accommodation circumstances made an inpatient withdrawal treatment more attractive. As Wal explained: 'people without stable accommodation may hope to gain entry to a detox unit to get a roof over their head and some food for a week.' In both of these cases, the scarcity of housing, and the policy and economic structures that underpin it, co-produce clients' enactment as clinical subjects. In one case, treatment is more limited than it might otherwise have been, and in another case, withdrawal treatment that might not otherwise have been provided took the place of emergency housing.

In addition to being unstably housed, Joshua was unemployed at the time of his clinical review. The presenting clinician's mention of social isolation and unemployment in the same sentence imply an understanding that they are causally linked. The clinician suggests that his co-occurring unemployment and social isolation might change in the future, as he does have some employment prospects: previous work had been 'good for him', and he is progressing towards a minor qualification that may attract employment opportunities. The significance of employment circumstances within the NSAODC, and clinicians' capacity to respond, is the next focus of this section.

Within the intake assessment protocols is a space for clinicians to detail 'Personal/social history[.] Current social situation and significant relationships'. This section includes fields for 'education, qualifications', and 'employment and income'. Of the 34 cases I saw reviewed, seven clients were identified as employed. In these cases, the following details were noted:

- He has a full-time job in construction ... He's conscious of alcohol use and its effects on work.
- He is employed full-time ... Works as a sales consultant ... He will be given a certificate for work.
- She works in the sex industry ... She feels safe in her brothel ... I told her about [two relapse prevention programs offered at



the NSAODC]. The sex work conflicts with the hours of those programs.

- He got a job as a chef ... His drinking is creating drama and he's worried that he'll lose his job.
- He started using speed for more energy at work. His boss knew, and was OK about it but now says he can't come back till he's sought counselling.
- She can't do [a NSAODC relapse prevention program] because of work. She had a fall at work a few months ago. Was this alcohol-related?

These observations suggest that clinicians view employment, AOD use and AOD treatment as mediating each other in various ways: work obligations sometimes prevent clients from attending treatment programs; employees can be motivated to address their substance use because of its impact upon their work; and work can motivate drug use by requiring an abundance of 'energy'. Some clients were not employed at the time of the clinical review, and this could also act, or be acted upon, by drug use and drug treatment. Two cases other than our case study client had their lack of employment noted:

- He used to work in construction until he was jailed for one year for trafficking cocaine.
- He took a redundancy package in 2010, and since then has drunk a bottle of whisky per day.

Some further causal flows between work and drug use are identified in these statements: unemployment can be associated with a shift to problematic drinking; and drug dealing can be associated with loss of employment (and imprisonment).

Twenty-four clients did not have their employment specifically mentioned in their clinical review. Four of these were studying, leaving 20 clients for whom no engagement with work or study was detailed. Looking closely at these data, a range of details suggest that the clients were unemployed. Three clients planned to go to a

long-term inpatient withdrawal service after withdrawal. One client was 69 years old and likely to have retired from the workforce. An 18-year-old client was ‘couch surfing’ in a peri-urban suburb, a difficult circumstance in which to hold down a job. Three clients received the Disability Support Pension, for which they would not have been eligible with adequate income from work. Three clients were described as being ‘supported’ by their mother. One client, who was a heavy benzodiazepine user, ‘likes to be stoned all the time’. One heavy poly-drug user lived in public housing. One young man who had aged out of state care lived in a boarding house. One client suffered from multiple, debilitating physical illnesses. One client had an ‘intellectual disability’. While none of these circumstances offers conclusive evidence that the client concerned was unemployed, this was, in each case, a likely scenario. Given that the employment circumstances of these clients were not specifically mentioned, I concluded that unemployment forms the ‘default setting’ or assumed circumstance among NSAODC clients.

The combination of housing problems and unemployment among many NSAODC clients was also deemed to be agential. As discussed in Chapter 6, unemployment and unstable housing are relatively common in Broadmeadows, and these form part of a broader picture of social disadvantage. Wal, discussing the circumstances of some of his clients from Broadmeadows, attributed these ‘grim’ socio-material circumstances with a causal role in AOD use:

It’s pretty grim out there in Broady [Broadmeadows] and some of the places and because we do outreach we see it and I wouldn’t like to live there. You know I’m comfy middle class and everything but it’s not a place that I look at and think “Wow, wish I was here. Yeah, life would be a lot better if I lived in this joint” ... I mean, I’m not consuming a lot of research to back it up but it’s an escape. It’s hard to see a future for a lot of people, or any sort of positive-move-ahead kind of future and, and Eddie McGuire [a prominent Melbourne television and sports personality] got out of there so it is possible, but um, I’m not sure that all that many people escape Broady.

Here, Wal positions AOD use among Broadmeadows residents as ‘an escape’ for people without a ‘positive-move-ahead kind of future’.

Clinicians recognise Joshua’s marginal employment and accommodation circumstances as entangled with his drinking and as co-producers of the problems associated with it. Furthermore, it is likely that his employment and accommodation problems were taken into consideration when clinicians were planning his treatment. These observations suggest that clinicians understand scarcity of housing and employment, and the policy and economic structures that underpin it, as mediators of AOD use and harms, yet clients are enacted primarily as having AOD problems rather than as having housing or employment problems.

### **Therapeutic jurisprudence**

The statements in the 13<sup>th</sup> and 17<sup>th</sup> sentences of Joshua’s clinical review give evidence of his legal circumstances: ‘He is not welcome at home and his mother has taken a restraining order against him after episodes of violence’; and ‘Charges are pending against him for being drunk in public, resisting arrest and breaching an intervention order.’ These sentences also suggest some involvement in violence. The sixth sentence of Joshua’s clinical review suggests that the client had been involved in a violent encounter soon before attending the intake assessment: ‘He presented with cuts on arms and knees from falls and scuffles.’ In this section I discuss some of the issues associated with forensic AOD treatment. I argue that there is a tension between enactments of punishment and treatment.

William told me that his forensic clients come to him through two programs: the Court Integrated Services Program (CISP), which operates from several Victorian Magistrates’ Courts but not at the Broadmeadows Magistrates’ Court; and the Court Referral & Evaluation for Drug Intervention & Treatment (CREDIT)/Bail program, which operates at the Broadmeadows Magistrates’ Court and other sites. According to program brochures, the aims of the CISP are to:

provide short-term assistance before sentencing for accused with health and social needs; work on causes of offending through

individual case management support; provide priority access to treatment and community support services, where possible; [and to] reduce re-offending rates. (Magistrate's Court of Victoria, 2013a)

In this program, problematic AOD use is positioned as a 'health and social need', or one of the 'causes of offending', or both. Clinical AOD treatment is provided as a humanitarian (meeting an offender's 'needs') and community safety (reducing reoffending rates) response. The CREDIT/Bail program aims to:

Minimise harm to the client and the community by addressing the client's substance abuse-related issues; Provide early treatment, including access to drug treatment and rehabilitation program; [and to] Reduce risk of the client re-offending. (Magistrate's Court of Victoria, 2013b)

In this program, AOD 'abuse' is positioned as a source of harm 'to the client and to the community' and a risk factor for further offences. According to the pamphlets, both the CISP and the CREDIT/Bail program are usually accessed via referral from a range of non-clinical sources. After referral, AOD clinicians conduct assessments and provide written advice to the court. William explained the approach he takes with his assessments:

The forensic ones, I draw up the CISP and CREDIT/Bail assessments, I then write a report on that, which is generally about four or five pages detailing the client's current situation including their current AOD use and past, housing, community connectedness, income or finances, relationships, family history, mental health, physical health, and basically it provides a story. Now, this is actually provided to the correctional or the CISP, CREDIT/Bail worker. They then provide that to the Magistrate. And the aim of this is to get an understanding of not just that the client used drugs and alcohol and got in trouble. It's understanding how this situation came to be, as best as possible.

And so that can essentially help to lessen the sentence for a client or get him into more appropriate treatment rather the punitive response.

Following the assessment, William makes a recommendation to the court about appropriate future treatment for the client:

For many of those clients, they end up going into counselling. Some end up going to withdrawal programs. Others, no treatment's required, but I've yet to meet someone for whom that's been the case.

William sees his role as providing a 'story' to the court to motivate a treatment rather than punitive response, and he had yet to encounter a client about whom that story could not be constructed. The story performs a causal link between life circumstances, problematic AOD use and offending practices. William recommends a course of treatment, which varies from case to case, but is almost always 'required'. The treatments serve to meet the offenders 'needs' and to minimise the harms their AOD use poses to them and to the community.

Literature on 'therapeutic jurisprudence' has considered some of the interactions between clinical and judicial roles and subjectivities. According to Fitzgerald (2008), where therapeutic jurisprudence applies to AOD issues (as opposed to disability or mental illness, where it is also relevant), it arises from a 'belief that, for drug crimes, treating offenders' addiction and promoting their well-being are more likely to reduce reoffending' (p. 105). Vrecko (2009) pointed out that one mode of activating the therapeutic jurisprudence of a court is a magistrate's logic of 'coding' and 'tabulation' (p. 225). This can involve numerical indices of 'blood alcohol levels, pattern of offences and number of convictions' (p. 225). With these tools a magistrate can identify offenders as having an AOD problem and refer them to a treatment program for assessment. Another way in which therapeutic jurisprudence can be activated is where offenders facing legal sanctions strategically activate the therapeutic jurisprudence of a court. Seear and Fraser (2014) argued that, when facing legal proceedings, 'drug users' (in which we might reasonably include frequent heavy sessional drinkers) would often be well advised to deploy a narrative

‘positioning them as acting out of a troubled past’ (p. 9). This can locate their AOD use, and the associated offending behaviour, as ‘an injury, effect, or consequence of trauma for which the “addict” bears no responsibility’ (p. 8), a performance sometimes resulting in an advantageous effect upon the outcome of the court’s deliberations. CISP clients interviewed for an evaluation of the program indicated that ‘they understood participating in the CISP program was likely to improve their court outcome’ (The Department of Justice, 2010 p. 8).

With reference to evaluative studies of therapeutic orders made by courts, Fitzgerald (2008) argued that therapeutic jurisprudence cannot be justified by its efficacy in reducing recidivism, or its cost effectiveness in comparison to custodial sentencing. Instead, he claimed that therapeutic jurisprudence is best justified as a mode of delivering ‘affective justice’, which he defined as a political need for the justice system to be seen to simultaneously punish and rehabilitate (p. 113). Vrecko (2009) asserted that this is not so much ‘the subsumption of medical authority under legal power, but the hybridisation of the two’ (p. 226). Seear and Fraser (2014) recognised that law, policy, and service provision are often ‘entangled, mutually interdependent and co-constitutive’ (p. 9), and this, I argue, is apparent in the case of forensic AOD counselling. With hybrid objectives, legal authorities assume a notionally clinical role of handling an AOD problem, and clinicians assume notionally legal roles of mandatory management of offenders.

Hybrid legal–clinical practices are an issue for a significant proportion of the NSAODC’s clients. Of the 34 clients I saw clinically reviewed, seven had pending legal matters noted, seven had no legal issues at the time of the review, and for the remaining 20 clients, no legal matters were mentioned. Of the seven with pending legal issues, one client’s court proceedings would cease if he attended withdrawal and counselling. Several charges related to breaking intervention orders. One related to graffiti, and another had broken into a shopping centre after drinking heavily and taking Xanax. William told me about a client of his, whose clinical review I did not observe, who crashed a car while intoxicated with alcohol. This incident led to his contact with the justice system and a subsequent referral to William. Assaults are also an event commonly making heavy alcohol use visible to the justice system and,

subsequently, to the NSAODC. William told me that, in relation to court-referred clients, he was aware of ‘a significant increase in alcohol-related assaults’ and that ‘if you put all the drugs together alcohol probably tallies [equals] the rest of them altogether in terms of assault’. William told me that he had about 30 forensic clients on his books at the time of interview, and that on the days where he sees forensic intake clients, he sees ‘anywhere between four and six clients a day. It’s really busy.’

Forensic AOD treatment is a large-scale phenomenon. Referrals from court diversion programs accounted for 23% of counselling support periods in Victorian AOD treatment centres in 2009–10 (Australian Institute of Health and Welfare, 2011a p. 10). In a study of an adolescent AOD treatment setting (Foster et al., 2010), 13 of the 19 participants had their treatment mandated by the justice system (p. 534). Howard’s (1993) review of issues concerning the treatment of young people with problematic AOD issues noted that: ‘Most adolescents do not come for assistance voluntarily; they are usually sent/coerced/threatened by parents, probation officers, solicitors, school authorities, courts, refuge/hostel staff, and so on’ (p. 114). Vrecko quotes O’Brien and Cornish (2006) noting that in the United States, ‘the criminal justice system is the major source of addiction treatment referral’ (Vrecko, 2009 p. 223).

Forensic treatment was evidently an issue within the NSAODC youth withdrawal unit too. This was particularly apparent during a ‘harm reduction information session’, in which a blurring of—and tension between—punishment and treatment emerged as a significant controversy. Four clients and two clinicians were working through checklist items on a sheet entitled, ‘What would be good about cutting down or stopping’. Clients made comments as they proceeded through the items. These included:

- I’d have to change all my mates;
- Before I lived in [northern suburbs area] I was an A student, I didn’t know what drugs were. It’s been four years straight. I love my drug life;

- I'm not ready to quit. Both times in here have been court orders;
- I'm not here because I want to quit. It's because of other circumstances;
- I want to keep all my mates; and
- I do drugs, that's all I do.

Here the clients suggest that, despite their involvement in treatment, they value and do not wish to alter their drug-using practices. Instead their motivation to attend treatment arises from 'other circumstances' or a 'court order'. There were other instances of clients disowning treatment goals that had been articulated for them. I observed an information session provided for two male inpatients at the youth withdrawal centre. The session aimed to make clients aware of the NSAODC's family counselling services, and motivate them to speak with their family about engaging the service. After the clinician presented a hypothetical scenario in which a subject's AOD use affected family members, the following exchange took place:

Clinician: Are there any questions?

[Silence]

Client 1: We're both here on court order. We're not ready to quit.

Clinician: Are you both going home to family?

[Both clients nod.]

Client 2: They'll just have to deal with it.

Client 1: I've already got five workers. My mum wouldn't look at it.

Client 2: People have the choice to take drugs.

Clinician: Do your families get that?

Client 2: Yeah.

[The clinician hands out pamphlets to each client]: Here're the details.

Please give these to your parents and family.

Client 2: Where's the nearest bin? Thanks for waking me up.

In these two exchanges, the clinicians proceed as though their clients are earnestly seeking assistance with AOD problems, while some clients state that they derive



pleasure from their 'drug life' and indicate that they are motivated to receive treatment by the justice system, rather than a desire to cease or control their use. The clients are enacting the clinical encounter as a punishment for the AOD-related crimes that have been so enacted by the hybrid AOD treatment/legal system and refuse to enact it as a treatment. The clinicians on the other hand, approaching their clients from a humanistic value base, are intent on enacting the process as a treatment. There is a clear tension between enactments of punishment and treatment, and a daily battle to secure it one way or the other is played out in the withdrawal unit. The status of clinical interventions as punishment or treatment is not clear or stable: it is imposed on ambiguous circumstances by various stakeholders with different agendas.

Discourses of therapeutic jurisprudence can have the structural effect of rendering interventions by the justice system as 'treatment' rather than as punishment. While, in many respects, it may be to clients' advantage to be placed in an AOD treatment setting rather than explicitly punitive custody, this process has other effects. First, mandatory AOD treatment foregrounds AOD use as the attributable force leading the young offender into offending. This reinforces normative constructions of AOD use and intoxication as dangerous, antisocial and destructive. It also draws attention and resources away from other forces shaping clients' lives. If clients' housing and family circumstances, unstable accommodation, unemployment, poverty or social isolation were foregrounded, then discourses of therapeutic jurisprudence may activate service responses to assist clients to address those issues instead. It may be that mandating young adult AOD users to access such services would meet with less resistance than AOD treatment does, and that assistance to find housing, work or social connections would less readily be enacted by them as punishment.

In this section I considered interrelations between legal proceedings, client drug use, 'treatment' and punishment. I speculated that Joshua understood his time in the withdrawal unit as a form of punishment, while his clinicians understood it as treatment. What is clear is that the therapeutic jurisprudence which makes the 'treatment' mode of ordering possible also has the effect of foregrounding AOD use

as problematic and backgrounding the role of other life circumstances in causal accounts of offending practices.

### **Multiple treatment episodes**

The fourth and fifth sentences of Joshua's clinical review briefly note some of the client's previous history with NSAODC and another AOD treatment service: 'He completed a withdrawal in 2009. He attended [organisation name], an evangelical rehab program, after which he was sober for two months.' This section will focus on the significance of multiple treatment episodes within the clinical work of NSAODC, and the significance of these enactments for understandings of change and progress in the treatment context.

A first point to note is that after he had completed his previous withdrawal treatment at NSAODC, Joshua was referred to a non-secular residential rehabilitation program for young men. Rehabilitation services were often a destination for clients completing withdrawal. They were most often based on an inpatient model where treatment periods typically last for months. This makes them resource intensive. Apart from a six-week outpatient relapse prevention program for alcohol users, and some longer-term therapeutic group meetings, the NSAODC did not provide rehabilitation services. Some of the rehabilitation services to which clients were externally referred were operated by religious organisations which, I assume, resourced their operations partly through fundraising activities. It may be that the faith-based orientation of these services enacts AOD use, 'dependence' and using subjects in very different ways to secular treatment services. While investigation into the operations of these groups is beyond the scope of my research, it is worth noting that faith-based interventions for young people with AOD issues comprise a significant component of the sector, and that this is partly related to the financial resources available.

It was very common for the clients whose cases I saw reviewed in clinical meetings to have commenced and discontinued treatment at NSAODC and other services multiple times. For example, one young man had completed 32 withdrawals. Of the 34 cases I observed in clinical reviews, none were disqualified because of multiple

unsuccessful attempts. Moore and Fraser (2013) discussed the systemic drivers for agencies to take on, and even engineer, multiple episodes of care. Repeated episodes of care are recognised as endemic to the system and are driven in part by funding imperatives. Clinicians told me that multiple episodes of care at NSAODC are driven by funding structures, but only insofar as the statistics are concerned; they seldom alter actual treatment practices. There is, however, another institutional force driving multiple episodes of care, one with demonstrably more impact upon actual treatment practices. I next focus on the significance of enactments of resumption of drug use after treatment.

One mode of enacting the resumption of use after treatment is via a distinction between 'lapse' and 'relapse'. Violet told me that the distinction between a lapse and a relapse is an integral topic in the alcohol relapse prevention program run by the agency. According to a harm reduction worksheet provided to withdrawal clients, 'a lapse is just a 'slip' in your plan to stop or control your drug use. A lapse is different to a relapse. A relapse means you have given up trying to stop or control your drug use.' Another information sheet in the same pack included the following:

*Learning from a lapse*

The steps to learning from a lapse into drug use are to ask yourself:

- 1: Why did I have the lapse? What was the high-risk situation?
- 2: What would I have preferred to do in that situation?
- 3: Do I need to change my coping strategies or contingency plan?

Enacting a 'lapse' is a strategy deployed to prevent the clients from 'giving up' trying to stop or control their use, and to continue to refine their skills for sustained control or cessation of use. The core of the model is the hypothetical subject who has 'given up' trying to control or cease his/her use, and clients who have not entirely abandoned their intentions towards moderation or abstinence need not be considered to have relapsed.

A related enactment of resumption of AOD use after treatment is via a cyclic and iterative model of addiction called 'stages of change'. Wal told me that his agency

used stages of change ‘just like everybody else in this field’. The assessment forms ask clinicians to locate clients in one of the six stages of change: ‘Pre-contemplative: Not aware of having problem’, ‘Contemplative: Considering making changes to improve mental health’, ‘Determinative: Aware of and preparing for actions to take change’, ‘Active: Ready to take action now or have done so recently’, ‘Maintaining: Looking for strengths to maintain changed behaviour’, and ‘Relapse: Resuming drug taking behaviour after a period of abstinence’. Prochaska and DiClemente (1986) developed this rubric, also known as the ‘Transtheoretical model’, for the generalised treatment of all ‘addictive behaviours’. Rather than making a distinction between a lapse and a relapse, this model figures resumption of use as a single discrete stage, although it too seeks to cast it in a hopeful light. According to literature about this model, ‘addiction’ is understood as a process of linear and non-linear movement between these discrete stages. Relapse is seen as ‘as a positive opportunity, rather than a failure to change problem behavior’, and it:

represents a successive learning process whereby the individual continues to redo the tasks of various stages in order to achieve a level of completion that would support movement toward sustained change of the addictive behavior. (Korsmeyer & Kranzler, 2009 p. 298)

This ‘successive learning’ approach to relapse is also evident in the harm reduction materials provided to clients in withdrawal treatment. One sheet asks clients to list ‘past strategies that I have tried’ and provides columns for ‘what happened?’, ‘success rating (10 is successful)’, and ‘which ones will I try again’. So models of understanding resumption of AOD use after treatment enact a subject who has some intention—a will—to moderate their use, and is in the process of ‘successive learning’, where they gradually acquire the skills necessary to achieve their goal. This enactment of clients renders multiple treatment episodes as a positive indication of the subjects’ progress away from problematic use.

While this model may provide a rationale for clients’ repeated access to treatment, it forecloses other possible enactments, some of which may offer more options for clients. The ‘successive learning’ models foreground AOD-using subjects’ will,

capacity for self-reflexivity and rational learning as the therapeutic target. Although these entities are treated repeatedly, that he or she continues to experience problems and returns for further treatment is not recognised as indicative of a shortcoming of the model. This has a structural effect of reinforcing enactments of addiction that perform it as a ‘chronic relapsing condition’, and at the micro level, has the effect of performing the client, rather than the treatment service, as having failed to achieve lasting change. An alternative enactment of repeat episodes of care might recognise these as cases where treating the clients’ will and rational thinking has not been effective. Such recognition might allow clinicians to foreground other forces at work in AOD assemblages and direct their efforts towards altering these.

For the clinicians, Joshua’s repeated presentations at NSAODC were understood as opportunities for successive learning. The data do not provide any indications about how Joshua might have understood his pattern of treatment and ‘relapse’. I believe that, to the extent that he internalised the clinicians’ enactment, he understood that his will, capacity for self-reflexivity and rational learning were, as yet, insufficient to the task of achieving lasting change. This individualisation of the ‘problem’ and its solution serves to de-emphasise and de-politicise Joshua’s structural disadvantages. While no other modes of ordering are evident in the data, I have argued that they are possible, and that they might be more effective than the ‘stages of change’.

## **Conclusion**

This chapter and the one preceding it were focused on Joshua’s clinical review in the NSAODC to present various modes of ordering young adults’ heavy sessional drinking and associated phenomena. I have shown multiple modes of ordering dosage, ‘primary drug’ and other drug use, young adult alcohol clients, abuse, dependence and withdrawal, mental health, accommodation and employment, therapeutic jurisprudence and multiple treatment episodes. I have demonstrated that each of these topics is the subject of controversy. I will now conclude by arguing that each of these controversies can be understood as a contest between *aggregated*, *humanist* and *situated* realities.

First, we might characterise the clinical science modes of ordering as *aggregated* realities. They are pre-coded within diagnostic criteria, assessment protocols, institutional and disciplinary demarcations, and information materials provided to clients and their families. Aggregated logics enabled alcohol to be attributed with a role in instances of dependence, violence, and criminal and risky practices. These attributions led to the enactment of Joshua as a problematic drinker. They are crafted for coherence at an abstract level so that a single sense may be made from many possible scenarios. They tend to postulate unidirectional causal flows and discrete, rather than fluid states of affairs. They are totally blind to the specific contours of clients' familial, social, affective and material circumstances, but are used for crafting coherent statements about AOD use at the population level, such as statistics showing the relative burdens of various substances upon the treatment system. They take alcohol and other drugs associated with dependence and abuse to be the principal cause of clients' problematic life circumstances. While the clinical instrumentation does have some taxonomic sensitivity to troubled housing, employment, and health circumstances of clients, these appear as a backdrop to the flows of causal efficacy. The dominant theme is that effects of AOD use are caused by alcohol and other drugs, and changing AOD use practices is the key to improving life circumstances and protecting the community from individuals afflicted by volatile and destructive pathologies.

I characterise another prevailing logic within the NSAODC as *humanism*. Humanist values were coupled with recognition that clients were vulnerable and lacked resources. They framed clinical encounters as benevolent insofar as they deployed institutional and state resources on behalf of those with very limited private means. Recognising clients as disadvantaged enabled the construction of multi-directional and complex causal flows between mental and physical health, material life circumstances, emotional habits and skills and AOD use, which contrasted with the unidirectional flows enacted by the aggregated accounts. Sometimes, humanism motivated enactments of dependence or withdrawal or comorbidity that conflicted with propositions of the aggregated clinical science. In these cases, clients did not meet the diagnostic criteria formally making them eligible to receive services, but this was overlooked so that the client might have the benefit of a supported period of

‘withdrawal’. In these instances, the humanist enactments trumped aggregated ones. However, humanist enactments were complicit with aggregated ones insofar as they participated in the structuring of troubled social, affective and material circumstances as, first and foremost, AOD problems. Many of the forces shaping client life circumstances were outside the disciplinary boundaries or resource capabilities of AOD clinicians. While they demonstrated an understanding of the complex causality of AOD-related issues, clinicians’ primary role was to enable clients to manage their thoughts, feelings and behaviours in relation to AOD use. When other forces were at work, clinical intervention was limited to advocating for different understandings of their clients’ needs among others who handle them. Examples documented in Joshua’s clinical review and the wider data include liaising with doctors regarding treatment regimes; constructing a ‘story’ for a court to motivate a treatment rather than a punitive response; or providing referrals to housing services. These humanist responses were about the best that could be achieved within the regime dictated by the aggregated realities, which defined most of the terms for deploying the institutional resources. Despite their humanist intentions, working within these boundaries had the side effect of reinforcing realities in which malign substances and the rationality and will of those who abused them are foregrounded as the source of life problems. In this sense, humanism was complicit in consigning to the background socio-material structures such as labour and housing markets, and welfare and justice regimes. This depoliticised clients’ circumstances, and as Ticktin (2006) argued, ‘emphasises benevolence over justice, standards of charity over those of obligation’ and ‘ultimately protects and encourages a limited and limiting notion of humanity’ (p. 42).

A final mode or ordering I described, *situated* realities, sometimes emerged in resistance to aggregated and humanist enactments at the NSAODC. These enacted dosage in typologies of intoxicated states that were relative to variable tolerance, skill, and poly-drug use. They could be used to foreground the therapeutic benefits of alcohol use in response to mood problems and the socially integrative aspects of clients’ ‘drug life’. They defined mandated withdrawal periods as coercive punishment and resisted notions of ‘treatment’. In my analysis of the data I argued that situated modes of ordering could be deployed to resist interdisciplinary

demarcations that place non-dependence forming drugs off the agenda. I also contended that situated reasoning could be applied to a reappraisal of the clients returning to treatment after ‘lapsing’ or ‘relapsing’. Clinicians’ interventions are often insufficient to alter the forces driving AOD issues in clients’ lives. Multiple episodes of treatment suggest that the other services handling AOD clients are similarly ineffective in transforming these forces. The data implicate a wide array of forces in co-producing the effects of AOD use: income, welfare and employment circumstances; traffic accidents and physical injuries; families, family relations and family conflict; partners, relationships and domestic violence; social and peer relations and their connection to a workplace; access to housing and homes, drug-using cohabitants, and drug markets in the neighbouring area; mental health problems, including depression, anxiety, personality disorders and the legacies of childhood trauma; doctors, pharmacies and prescribing regimes; and service systems including mental health, justice, accommodation, social work and their associated entanglements with legal proceedings. In a context of multiple treatment episodes, a situated analysis of these assemblages might reveal opportunities for interventions that improve clients’ circumstances and obviate further AOD treatment. Clinicians intuit that situated modes of ordering promise improved therapeutic outcomes, but lack the scientific reference points to feel confident about deploying them. These observations strongly imply that researchers should trial and assess the efficacy of situated modes of ordering. It may be that situated techniques help clinicians to work on the things that really matter to clients, and allow treatment goals to be more empowering and effective.

In emphasising the possibilities of situated modes of ordering I do not mean to suggest that the client’s own mode of ordering should be adopted uncritically by the clinician. Rather, I am suggesting a more explicit sensitivity to the multiplicity of possible modes of ordering client circumstances, and a greater readiness to set aside the strictures of aggregated science. My study is not the first to advocate for such practice. In 1910, the pioneering social worker Jane Addams wrote that she ‘dreaded’ that social work might lose its ‘flexibility, its quick adaptation, its readiness to change its methods as its environment may demand’ (Addams & Wald, 1910 cited in Carr 2010, pp. 226–227). A century later, Carr (2010) elaborated on Addams’



argument in her ethnographic study of a residential AOD treatment facility for women, suggesting that social work might be taught as ‘practical ethnography’:

Teaching social work as practical ethnography suggests, in line with Marilyn Strathern’s (1988) elegant description, a practice of reflexivity grounded in the idea of “parallel worlds”. This means that the practitioner must always account for his or her own way of interpreting specific circumstances in relation to how his or her clients interpret them. As I regularly tell my own students: only when they are able to account for the difference between their own situated interpretations and those of the people with whom they work will they be prepared to formulate sensitive and effective interventions. I underscore that this does not mean that they abandon their interpretations, but rather that they work to patiently formulate them in tandem, or parallel, with their clients. Just as good ethnography is not simple reportage of the “native point of view,” good social work is not a matter of simply adopting or valorizing a client’s perspective over one’s own. (Carr, 2010 p. 231)

Here Carr argues for a sensitivity to ‘parallel worlds’ or, in the language of STS, to multiple modes of ordering. This must include sensitivity to a client’s specific circumstances, and the specific inclusion of the client’s ‘perspective’. Carr emphasised the co-production of interpretations of client circumstances ‘in tandem, or parallel’ with the client themselves. Just as good ethnography patiently seeks to refine theoretical insight from situated observation, and is necessarily bound to a process of iterative reformulation (Agar, 1996), good clinical social work is an iterative process of reformulating multi-modal problems, and patiently advancing concomitant solutions.

Mol, Moser and Pols (2010) made a similar argument in their study of various practices of care. In care practices:

...local solutions to specific problems need to be worked out. They may involve “justice”, but other norms (fairness, kindness, compassion, generosity) may be equally important ... [Care practices are] a special modality of handling questions to do with the good ... Care implies a negotiation about how different goods might coexist in a given, specific, local practice. (p. 13)

Here, Carr’s ‘parallel worlds’ are reformulated as multiple ‘norms’ and orders of the ‘good’. This argument suggests that clinicians at the NSAODC would do well to gather different combinations of forces into multiple modes of ordering, construct different versions of the problems and iteratively try their concomitant solutions. It means making only humble claims about the broader applicability of individual solutions, recognising that they only represent one possible gathering of elements and perform only a few versions of the ‘real’ situation, among a much wider range of valid possibilities. Instead, clinicians might take a finite range of forces gathered in a client’s AOD assemblages and gather them into a tentative formulation of a problem.

For Joshua’s case study, I have already proposed one alternate enactment of the problem—the causal role of escitalopram and varenicline—but there are many other possibilities. A clinician might, for example, gather the observations about Joshua’s social isolation and unemployment and use them to propose that the client is often bored and lonely and sometimes drinks heavily on these occasions. In this formulation, the mixture of affects in these occasions might be understood as coalescing into events such as those leading to Joshua’s legal entanglements. From this formulation, the clinician might set themselves the task of providing material support and advocacy to assist the client to complete his forklift training and find employment. This course of action might bear fruit and begin to mitigate the client’s boredom, loneliness and heavy drinking, and their emergent effects. Similarly, this course of action might be derailed by some hitherto unattended force, in which case the clinician might reformulate the problem using a different set of forces and reconstitute the concomitant solution. Such an iterative process might involve multiple episodes of care, but these would not necessarily be enacted as movements between the discrete subjectivities of the ‘stages of change’. In that enactment, there

is only one problem—the clinical subject’s AOD use—and only one solution: his permanent shift into the ‘maintaining’ stage. In the situated mode of ordering, the multiple episodes of care would instead be seen as a process of the clinicians and the client partnering in an iterative process of problem reformulation.

# Chapter 10

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## Conclusion

This research was motivated by three questions. First, how is heavy sessional drinking among young adults and its problems currently enacted within significant sites of research, policy and service provision? Second, what are the effects of these enactments? Finally, how else might it be enacted? The questions were approached from an overtly political concern with challenging the dominant neoliberal account in which ‘risky’ drinking is associated with failure to adequately develop self-enterprise, and proposing an alternative analysis in which assemblages of socio-material forces are attributed with the harmful outcomes of drinking sessions. In responding to these questions from this political disposition, I used theoretical orientations and techniques drawn from STS to develop an ethnographic account of heavy sessional drinking across multiple sites. The sites were presented such that each influential disciplinary enactment had its ethnographic counterpoint. Alcohol epidemiology was contrasted with the drinking events of young adults in Broadmeadows; Victorian and Commonwealth policies were contrasted with events at a Broadmeadows football club; and the aggregated scientific definitions of clinical phenomena were contrasted with the humanist and situated realities clinicians and clients negotiated within an AOD clinic. Within this structure, I detailed enactments of heavy sessional drinking among young adults in three influential disciplinary fields, considered some of their effects, and proposed alternatives. This concluding chapter is presented in five sections. First, I summarise my challenges to the consumption-as-harm proposition. Second, I outline my challenges to the social constructionist orthodoxy. Third, I detail my contributions to STS-informed work in this space. Fourth, I suggest some directions for further research, and finally, I close by posing a theoretical question to the field.

### **Challenging the consumption-as-harm proposition**

Across the disciplinary sites in this study, the consumption-as-harm proposition was ascendant. To adopt the language of causation used in epidemiological theory, the

consumption-as-harm proposition holds that alcohol is a necessary but not sufficient cause of acute alcohol-related harms. Alcohol cuts across all situations of alcohol-related harm, so its consumption must remain at the centre of the causal proposition. Following this reasoning, alcohol research, policy and clinical practice is preoccupied with managing consumption of the substance.

Within the epidemiological studies of morbidity and mortality, a choreography of practices positions alcohol as ‘causing’ ‘deaths and morbid events’, ‘in preference’ to being ‘associated with’ or ‘related to’ these outcomes (English et al., 1995). This is aided by the constitution of three collateral realities: alcohol is a stable pharmacological agent that acts independently and consistently and produces quantifiable effects; alcohol effects are most visible at the population level and therefore populations rather than individuals are the entity of primary public health concern; and social or other ‘factors’ may amplify or diminish the force of alcohol effects by altering the volume of alcohol consumed but not the causal relationship between alcohol and its effects.

In Victorian and Commonwealth policy documents, heavy sessional drinking among young adults has increasingly been enacted as a function of ‘drinking culture’. While the definitions of ‘drinking culture’, and the entities used to co-constitute it, varied widely, the primary concern across the policy documents is the relationship between drinking culture and alcohol consumption. Other expressions of culture in the context of drinking practices, including those associated with masculinity, were outside the purview of policy initiatives to change drinking culture.

Clinical science has developed a manifold of interlocking propositions that define some AOD users and the drugs they use as problematic. In the case of heavy sessional drinking, these propositions position alcohol as the effective master agent driving the unfortunate life circumstances common among clinically defined alcohol abusers. At the NSAODC, these propositions are woven into psychometric instruments, assessment tools, funding arrangements and interdisciplinary demarcations. They mandate clinicians to intervene in clients’ lives in ways that serve to control AOD consumption. Despite their humanist politics, clinicians may

address other problematic aspects of their lives only insofar as they serve this primary goal.

I have argued that the consumption-as-harm proposition entails simplifications, and that these simplifications have political effects, which include the erasure of component causes. In case studies of drinking events in Broadmeadows, I noted some outcomes of drinking events: a pedestrian being hit by a car; an assault; a gatecrashed party with police attendance; and apprehension of violence in a public place. These outcomes were transformed by patterns of relations within drinking events: family and ethnic relations to alcohol and associated memories; gender norms; access to housing; conflict between young drinkers and their family members; interdependencies between marginalised friends; economic and institutional dis-integration; and systems of exchange. Had these component causes been otherwise, the alcohol-related harms observed would not have emerged as they did. While managing consumption is a logically viable response to alcohol-related harm, it is only one; many others are possible. Adding new causal propositions is a step towards new articulations of the problem, and new responses to it. This move from an assessment of social ‘factors’ in the epidemiological account, to the assessment of social forces in the case studies, renders the socio-material networks in which young drinkers are enmeshed accountable for the harms they co-produce.

While moving beyond the consumption-as-harm proposition is well justified within the language of necessary, sufficient and component causes, in the STS-informed language of assemblage thinking, it is unavoidable. Throughout this thesis I have endeavoured to highlight the ontological, methodological and political ramifications of assemblage thinking for the study of heavy sessional drinking among young adults. The consumption-as-harm proposition is not viable within this theoretical territory because of its attribution of stable agential qualities to alcohol. An ontological grounding in what things *do* in practice, rather than what they *are* in abstracted terms, necessitates that alcohol be understood as fully mediated by the array of forces at work in any event of consumption.

## **Challenging the social constructionist orthodoxy**

In taking an assemblage approach, this study is differentiated from the social constructionist canon of AOD research. The differentiation has primarily been achieved by reversing the usual convergence between the emic and the etic, and between the macrosociological and the microsocial. Instead I have shown how alcohol and its effects are made differently at various scales and discursive sites. Underlying this manoeuvre is an ontological proposition which holds that alcohol is not a stable entity with predictable effects, but an emergent one with always contingent and situated effects. I have argued that to understand what alcohol is and does is to map its interrelations with a wide cast of actors, actants and practices. The point of departure has been to highlight the differences and controversies, rather than seeking to confirm a specific proposition through convergence. In the NSAODC, I identified aggregated, humanist and situated modes of ordering alcohol use and other clinical realities. In the public policy geared towards changing drinking culture, I identified the shifting valences of gender, from a co-constituent of drinking cultures, to an unexamined artefact of statistical data on alcohol-related harms. In epidemiology concerning alcohol-caused mortality and morbidity, alcohol shifted from the status of a component cause at the individual level to a necessary one at the population level, with the application of aetiological fractions.

Unlike the social constructionist literature, I have also been explicit that causal accounts, including mine, always absent many of the forces making things happen. Research is an inherently political act, making some configurations of the real (and some causal accounts) more probable, and others less so. A concern with ontological politics, and the overt commitment to making the politics of empirical research explicit, is a defining feature of assemblage thinking. My argument in each of the site dyads has been that currently dominant modes of ordering serve to erase the agency of socioeconomic disadvantage in drinking events. My specific goal of making disadvantage present and accountable has guided the choices I have made as I gathered, analysed and presented my data. These have included the geographic focus on Broadmeadows, the selection of patterns of relations in the event case studies, the selection of 'hegemonic masculinities' and power hierarchies as analytic tools, and the focus on disadvantage within the clinical data. In each of these sites, I have

endeavoured to make disadvantage and social stratification more visible and accountable for the harms they co-produce, thereby making them worthy of intervention. These are significant points of differentiation between my work and social constructionist qualitative research on heavy sessional drinking among young adults in Australia.

Jettisoning an exclusive commitment to the symbolic also marks a point of departure. The flat ontology I adopted, in which the material and symbolic properties of agential assemblages are always intermingled, required an engagement with materiality. With this proposition in mind, I have argued that, in the data presented, private houses, football clubhouses and employment co-produced benign event outcomes, while public parks, car parks and unemployment co-produced harms. These insights would not have been possible from within the social constructionist framework. Beyond their theoretical import, these insights are significant because they create grounds for interventions that might craft the materialities of drinking events in less harmful ways.

### **Contributing to STS-informed AOD research**

In this thesis, I have played out some of the implications of STS for the study of young adult heavy sessional drinking. From the broader field of STS, I have applied specific methodological techniques from Law (2011a) (analysing choreographies of practice), Mol (2002) (characterising multiple modes of ordering) and Latour (2005) (following controversies). I have also drawn on AOD-specific STS-informed and assemblage-oriented literature. In my case studies of drinking events, this has included an empirical focus on events (Dilkes-Frayne, 2014), a definition of harm that turns on drinkers' ability to assert agency and to feel and operate in the world (Bøhling, 2014; Duff, 2014) and an analytic focus on 'what kinds of associations, between what kinds of actors, objects, entities, actants and forces, are involved in the production of ... [alcohol-related] problems' (Duff, 2013 p. 169). In the culture change dyad of sites, I focused on the absence of attention to masculinity in alcohol policy (Manton & Moore, 2015), attended to the co-constituting relations between AOD use settings and performances of masculinity (Farrugia, 2015), and theorised the football club as a hub or node of multiple intersecting forces acting at scales



beyond the club itself (Kelly et al., 2011). In the analysis of clinical practices, I identified more fluid relations between comorbidities (Fraser et al., 2014), clinical enactments of multiple episodes of care (Moore & Fraser, 2013) and co-constituting clinical practices and therapeutic jurisprudence (Seear & Fraser, 2014). In all these ways I have drawn on the insights of scholars in the STS field.

In turn, this thesis makes further contributions to the field. For example, while many of the studies listed above feature close readings of qualitative or textual data from specific sites, I have woven together multiple data sources from multiple sites to achieve the first such study of STS-informed alcohol research. A further contribution is the technique of pairing dyads of disciplinary and counterpoising sites, which may be replicated by later studies similarly interested in critiquing dominant enactments. The review in Chapter 2 represents a novel summation and critique of contemporary qualitative Australasian literature on young adult heavy sessional drinking. This section will be useful to scholars who wish to further explore the applications of STS to the alcohol field. Finally, an STS-informed interrogation of the epidemiology of harms associated with specific substances is a useful technique for researchers concerned with drugs other than alcohol. Chapter 5 provides a useful example for how such a task might be undertaken.

### **Directions for further research**

In light of the arguments in this thesis, further research might thicken, rearticulate, add detail, and enact at different scales, causal accounts in which socioeconomic structures are implicated in alcohol-related harms. For example, quantitative researchers could test some of the patterns identified in microsocial data presented here against a broader population (Agar, 1996). In light of my analyses from Chapter 6, such studies might explore whether the social forces of family, ethnicity, memory, drinking settings and systems of exchange act differently among low-SES young adults than their more fortunate counterparts. Researchers could investigate associations between SES and young adults' access to housing, transport, and other material supports during drinking events. They might also investigate the distribution of unpleasant memories and thoughts about life's difficulties across the SES spectrum, and further document the agency of such cognitions within drinking

events. Building on the work of Lindsay (2006) and Pyke (1996), further studies could explore the interrelations of social class, enforcement of gender norms in public spaces, and alcohol-related harms. Further studies might also explore the intergenerational negotiation of drinking norms among migrant families and consider any differences between SES groups. While these findings would not necessarily provide causal insights, detailed descriptions of patterns of associations can highlight the limits and possibilities for intervention (Abbot, 1998 p. 176), and point towards reconfigurations of socio-material networks to reduce alcohol-related harms associated with disadvantage.

In light of my analyses in Chapter 7, policymakers might reconsider their focus on alcohol consumption, and concentrate their efforts for change on dominant masculinities within drinking cultures. In the Broadmeadows Bats case study, the Good Sports Program has not affected as much change outside the clubrooms as it has within them, because outside, a mode of masculinity that practises ‘bad behaviour’, ‘drink’ and ‘trouble’ still dominates. Its dominance is held in place by takeaway alcohol products, the football ground and its car park, the football club and its history, council regulations and their lack of enforcement, and continuity of historical norms—particularly modes of masculinity reproduced within families. Further research could profile the dominant masculinities within different football clubs, or other entities with problematic ‘drinking cultures’, and the webs of socio-material relations holding each in place. Where masculinities practising ‘bad behaviour’, ‘drink’ and ‘trouble’ dominate, further research might investigate initiatives to weaken the web of elements holding them in place. More radically, further research could explore possibilities for the institutional empowerment of women and men from traditionally subordinated subjectivities to occupy positions of cultural and institutional leadership within community sporting clubs, further disrupting the hegemony of aggressive masculinities.

In light of my analyses in Chapters 8 and 9, those developing the definitions, nosologies, guidelines, psychometric instruments and other devices for ordering clinical realities might note that, in the NSAODC, their instruments are readily disregarded, and to that extent, lack efficacy. If further research were to establish that

these patterns were observable elsewhere, it might motivate clinical science to develop enactments allowing for more fluid landscapes of pathology, more humane allocations of care and resources, and more complex accounts of the causal flows between substance use and life circumstances. These enactments could prove more obdurate and useful for clinicians and encounter less resistance from clients. They might also enable clinical treatment to more often meet its own therapeutic goals. The frequency of repeated episodes of care suggests that treatment outcomes very often fall short of treatment goals, at least in the medium and longer term. At present, repeat episodes of care are understood in terms of the ‘transtheoretical model’—that repeat episodes of care indicate change, or lack of change, in a client’s will and rationality—but in light of my observations, it could be reappraised and heeded as a signal that other forces need ‘treatment’ as well. Housing, employment, interpersonal relations, legal entanglements and other socio-material circumstances clearly play a role in co-producing AOD use and AOD effects, so these dimensions might also be ‘treated’ in order to achieve clinical goals. The data I presented show that clinicians look for scientific evidence to underwrite what they intuit to be useful treatment approaches with their clients, but often find only simplistic and ill-fitting models. If clinicians had an evidence base to underwrite broader socio-material interventions, they might be more empowered to act on these fronts. With broader recognition of clinical care as ‘practical ethnography’ or as situated negotiations of multiple orderings of the good, broader socio-material interventions could partner with clients to iteratively reformulate problems and their concomitant solutions. The situated mapping techniques Clarke (2005) and Carr (2010) defined would provide a fruitful structure for this approach.

### **Which way from the specific to the general?**

In the penultimate section of this conclusion, I will pose a question to the field that arises from my research.

STS-informed AOD research is still highly novel, and its application in an alcohol study of this scale is unprecedented. One of the techniques I have adopted from STS in this thesis is its method of following lines of causality from the microsocial worlds

to a more generalisable scale. Doing so has generated fresh insights, but it has also pointed towards some of the current limitations of this approach.

In studying heavy sessional drinking across different field sites, a wide array of the forces at work in co-producing the outcomes of drinking events has been brought to light. What, it is reasonable to ask, is the generalisable significance of these insights? The response of mainstream sociology would be that the causal accounts presented are limited to the specific circumstances of the case studies; that ethnographic methods are not suited for making causal arguments at the population level; and that further investigation of the patterns identified in ethnographic research by quantitative sociological or epidemiological studies would be required for broader assertions. These responses have motivated my suggestions for further research in the section above. However, I argue that many of the patterns of relations between alcohol and socio-material networks identified here plausibly exist at a scale beyond the specific circumstances in which the data were gathered. Carparks, wall signs and masculinities are all but ubiquitous at licensed sporting clubs. Conflicting perspectives on punishment or treatment are common in AOD clinics seeing forensic clients. The search for a weekend free house in which to stage drinking events is common among groups of young adult drinkers, especially in areas without suitable licensed venues. While, within the STS causal framework, no claims about the stability of the causal chains between these patterns and alcohol-related harms are possible, I contend that the patterns of relations described in my research possess broader explanatory power for the alcohol harms evident in low-SES populations.

Different theoretical orientations postulate different pathways from the specific to the general. Alcohol epidemiology lays claim to its explanatory power by studying simple alcohol effects on a population scale. Social constructionist alcohol research lays claim to its explanatory power by separating data into constituent elements, thematising and distilling them into structural forces, and jumping from the micro to the macro by converging them into a single reality. In contrast, I have clamped my explanatory chains to specific, observable actors, actants and practices. I have held events together, populating them as thickly as possible with specific empirical details. I have found the macro at work in the micro by identifying large-scale

patterns that mediate intimate relations between alcohol and bodies and other agents making a difference in drinking events. However, qualitative assemblage-style analyses are a relative newcomer in AOD research and there is, as yet, little consensus on the significance of its methodological pathway from the specific to the general. In order for the explanatory power of assemblage-style analyses to be harnessed for the benefit of policy development and service provision, further work is required to refine and build consensus upon this methodology. Latour has argued that generalisations should be a vehicle for travelling through as many differences as possible—thus maximising articulations—and not a way of decreasing the number of alternative versions of the same phenomenon (Latour, 2004 p. 221). Harnessing this insight for the purposes of advancing the policy and practice concerns of a harm reduction agenda will require further work.

## **Conclusion**

This new theoretical orientation offers much to the project of empowering AOD users and public health professionals to better realise the benefits and avoid the pitfalls of AOD use. However, there remains a question as to how we might best communicate the possibilities of these new approaches to the broader AOD field. My sense is that this kind of work will continue to encounter resistance, and that it will take strategy and ingenuity to disrupt the ‘new public health’ orthodoxy. The majority of alcohol scholars remain firmly committed to a representationalist epistemology, whether that is expressed in quantitative scientific realism or qualitative social constructionism. Recognising the performativity of alcohol science does not imply that it is mere invention and without merit, rather it is to suggest that it, like all science, is partial and methodologically mediated, and that it obscures other forces to which ‘the problem’ might equally be attributed. Pursuing a representationalist epistemology despite the insights of STS suggests a political crusade against a pharmacological substance rather than against effects associated with events of its use, many of which are agreed to be harmful. By adopting an STS-informed approach, the possibilities for effective intervention multiply rather than diminish. I offer this thesis as a small step in this direction.

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