

**Faculty of Health Sciences**

**Making Methamphetamine: Enacting a Drug and its Consumers in Scientific Accounts,  
Personal Narratives and Service Provision**

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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 acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

This thesis includes one original paper published in a peer-reviewed journal published as:  
Thomson, Nicola & Moore, David (2014) 'Methamphetamine "facts": The production of a "destructive" drug in Australian scientific texts', *Addiction Research & Theory* 1(12).

This paper is based upon Chapter 4 of this thesis. The ideas, development and writing up of this paper were the principal responsibility of myself, the candidate, under the supervision of Professor David Moore and Assoc. Professor Suzanne Fraser. The inclusion of Professor Moore as a co-author reflects his guidance and input as my primary supervisor.

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5.10.2014

## Abstract

Methamphetamine is an illicit stimulant variously referred to as ‘speed’, ‘crystal’, ‘ice’ or ‘meth’. Used globally, consumption of this drug was detected in Australia in the late 1990s. Since this time, methamphetamine has become the object of significant scientific, policy, treatment and media attention. In this thesis I critically analyse this attention by tracing the constitution of methamphetamine and methamphetamine-using subjects in the fields of science, policy, treatment and media. I also examine methamphetamine-related practices: the ways in which people consume this drug and service provision related to methamphetamine use. I do so in order to explore how authoritative discourses shape these practices and how consumers and service providers draw upon, reject and subvert hegemonic understandings of methamphetamine in their day-to-day lives.

Two main research questions informed my investigation. First, how are methamphetamine and methamphetamine consumers constituted in scientific, policy, treatment and media discourse? Then, in order to explore the material and political effects of these discourses, I asked: how do consumers and service providers draw upon, reject and subvert authoritative discourse through consumption and harm reduction/treatment practices? To address these research questions, I employed concepts from the theoretical fields of post-structuralism and science and technology studies (STS). These areas of scholarship reject the assumption that the world is a singular, stable, anterior phenomenon. Instead, reality is considered multiple; as continually ‘made’ through various practices and, being shaped by epistemic forces, as inherently political. Using these theories allows the investigation of methamphetamine as an ontological concern.

Drawing on the work of post-structuralism and STS entailed a methodological approach that could address multiple and inherently political realities. Thus, in order to carry out my research, I employed a ‘method assemblage’ approach (Law, 2004). This methodological arrangement addresses the multiplicity, interactiveness and contingency of realities. It is an approach that assumes that research practice is performative, creating particular realities while making absent and even suppressing others. In this sense, method assemblage is unavoidably political. It obliges the researcher to be cognisant and reflective of practice, being aware of the objects, subjects, practices and spaces that are constituted through method. It is also a commitment to enacting realities that are less oppressive — ‘to make some realities realer, others less so’ (Law, 2004, p. 67).

My research practice involved two methodological stages. I reviewed authoritative literature concerning methamphetamine to track the ways in which methamphetamine and methamphetamine-using subjects are constituted in scientific, policy, treatment and media discourses. I also conducted in-depth interviews between July 2009 and February 2011 with 13 service providers and 28 people who used methamphetamine in order to explore consumption and service provision practices productive of this drug and drug-using subjectivities. I recruited service providers through seven alcohol and other drug (AOD) and/or health services in an inner city suburb in Melbourne. People who used methamphetamine were also recruited through these services or by snowballing.

Through an analysis of scientific texts, I described how the materiality of methamphetamine is constituted as a singular and stable phenomenon. I argue that methamphetamine has been constituted in scientific texts as a ‘hyper’ stimulant — dependence-producing and harmful — with crystalline methamphetamine inscribed as a specifically potent and destructive form of the drug. My aim in this exercise is not to reveal the ‘truth’ about the nature and effects of this drug. Rather, I seek to make visible some of the work involved in establishing scientific facts and to underline the contingency of facts, as contradictory statements come to light and rhetoric is employed to support various claims and beliefs about methamphetamine.

To trace the constitution of methamphetamine-using subjects in authoritative discourse, I analysed key policy, treatment and media texts. This revealed the binaries that shape methamphetamine-using subjects, including voluntariness/compulsivity, controlled/chaotic and addict/clean. I argue that, in the case of methamphetamine, these binaries are ‘extreme’ — enacting bodies in ‘hyper’ absolutes. Methamphetamine-using subjects are materialised as specifically anxious, violent and chaotic and yet, paradoxically, these bodies are simultaneously enacted as specifically active drug users, able to be self-reflective and controlled. Foregrounding practice revealed that these bodies have different capacities but are shaped by the same assumptions — the centring and valorisation of the agentive, knowing and self-controlled subject, the fear of methamphetamine itself and disgust at the addicted subject.

My analysis of in-depth interviews with methamphetamine users explored the relationship between the ways consumers embody themselves and the absolutes enacted by scientific, policy, treatment and media discourse, and how hegemonic ideals are (re)produced and subverted in accounts of methamphetamine consumption. Participants’ accounts indicated

drug consumption practices were not clearly delineated in absolutes — suggesting that these practices are complex and multiple. Methamphetamine use may involve controlled, knowledgeable and ‘expert’ practices, yet this does not exclude individuals from understanding themselves as ‘addicts’. Likewise, constituting oneself as compulsive and out of control — compelled to take methamphetamine because of an addictive personality or traumatic life events — did not exclude highly agentic practices. Methamphetamine was used in order to capacitate bodies with power — to cope with trauma or to steal drugs. My research also attended to the material—semiotic networks that constitute methamphetamine-using bodies, showing how these capacitate bodies in particular ways. ‘Active’ practices and attributes such as ‘self-control’ and the ability to make the ‘right’ choices are shaped by the social and material connections an individual is able to make. Likewise, feeling ‘out-of-control’, ‘taken over’ by methamphetamine and other uncontrolled practices emerge from the relations an individual forms, and the assemblages they are enmeshed within, rather than a deficiency of will.

I also analysed accounts of service provision, showing how these practices oblige bodies to constitute themselves in specific ways and exploring some of the political effects of these embodiments. This analysis reveals the specificity of methamphetamine specialist treatment in service accounts, in which people using methamphetamine were conceived as highly knowledgeable and active. I foreground the concept of ‘change’ in service accounts, using the different ways in which treatment providers understood change in order to further examine the binaries that underpin drug use. The participating treatment providers employ conventional understandings of change, locating the capacity for change solely in the client. Yet, change also emerges as a more complex phenomenon. Sometimes change is conceived as a result of individuals making the right choices, but ‘chance’, environment, partners, homelessness and other aspects are also seen to play a role. Some workers need to see change in clients in order to find satisfaction in their work, and feel frustrated with clients who are not ‘ready’ to change. Others expressly stated they did not need to see change; some considered clients unchangeable and understood their practice as providing ‘respite’.

Accounts of methamphetamine use and service provision show the limitations and political effects of the absolutes of drug use. Moreover, illuminating how these absolutes shape practice reveals the ontological politics of methamphetamine and the contested nature of realities. People using methamphetamine are (like all individuals) constituted through the connections and relationships they form and to which they have access. These shape drug

practices — whether ‘controlled’, ‘chaotic’ or ‘functional’ — and the choices they can make. Individuals who use methamphetamine embody themselves through their local assemblages of use, but draw upon broader understandings of drug use as well. The bodies they ‘do’ both embrace and subvert the binaries of drug use. They are, at the same time — or at different times in their drug ‘careers’ — controlled, chaotic, extreme and knowledgeable drug users.

In this research I sought to disrupt the ‘facts’ of methamphetamine, arguing that all forms of knowledge are contestable. Using empirical methods, I scrutinised authoritative discourses that constitute methamphetamine and methamphetamine users in highly pejorative ways and illuminated their political effects. By treating the assemblages and networks of methamphetamine consumption and service provision as units of study, I have moved beyond research accounts that address drug use solely as the act of the pathological and deviant methamphetamine-using subject. This is both a political commitment to (de)centre the drug-using subject and a means to describe methamphetamine consumption and service provision in more complex and nuanced ways.

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## Abbreviations

AA	Alcoholics Anonymous
ABC	Australian Broadcasting Corporation
ADD	Attention Deficit Disorder
A&E	Accident and Emergency
AFL	Australian Football League
ANT	Actor network theory
AOD	Alcohol and other drugs
AMPH	Amphetamine sulphate
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
ATS	Amphetamine-type stimulants
CAT/T	Crisis Assessment and Treatment/Team
CBT	Cognitive behavioural therapy
CNS	Central nervous system
DHS	Department of Human Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
GHB	gamma-Hydroxybutyric acid
HREC	Human Research Ethics Committee
IDRS	Illicit Drug Reporting System
KIs	Key informants
NSP	Needle and syringe program
OST	Opiate substitution therapy
MA	Methamphetamine

NA	Narcotics Anonymous
MDMA	ecstasy: 3,4-methylenedioxymethamphetamine
METH	Methamphetamine
STS	Science and technology studies
SDS	Severity of Dependence Scale
UK	United Kingdom
US	United States

## Chapter 1: Introduction

Methamphetamine is an illicit stimulant that is variously referred to as ‘speed’, ‘crystal’, ‘ice’ or ‘meth’. Used globally, this drug was first detected in Australia in the late 1990s (Australian Crime Commission, 2001; Topp, Degenhardt, Kaye, & Darke, 2002a). Since this time, methamphetamine has become the object of significant scientific, policy, treatment and media attention. My research critically examines this attention, illuminating its political nature and specificity. I trace the constitution of methamphetamine and methamphetamine-using subjects in the fields of science, policy, treatment and media. I also research methamphetamine-related practices: the ways in which people consume this drug and service provision related to methamphetamine use. I do so in order to explore how authoritative discourses shape these practices — to show how people draw upon, reject and subvert hegemonic understandings of methamphetamine in their day-to-day lives. Two research questions have informed my investigation of methamphetamine and its related practices. First, I ask how are methamphetamine and methamphetamine consumers constituted in scientific, policy, treatment and media discourse? Then, in order to explore the material and political effects of these discourses, I ask how do consumers and service providers draw upon, reject and subvert authoritative discourse through consumption and harm reduction/treatment practices?

To address my research questions, I make use of the theoretical fields of post-structuralism and science and technology studies (STS). These areas of theory provide concepts that challenge Euro-American or modern Western views of ‘reality’ — that the world is a singular, stable, anterior phenomenon (Law, 2004). Instead, reality is considered multiple: it is continually ‘made’ through various practices and, shaped by epistemic forces, inherently political (Mol, 1999). Employing these theories enables the investigation of methamphetamine as an ontological concern, moving beyond the assumption that it is a singular entity with reified material properties. Instead, I address this drug as a fractured object, inscribed through a range of practices, where some practices have greater authority to determine what methamphetamine actually ‘is’. In the same way, methamphetamine consumers are addressed as multiple subjects — with the understanding that people embody themselves in different ways, depending on the practices involved, their environment and the connections and relationships they form to other subjects and objects. Foregrounding the practices of methamphetamine consumption and service provision, I argue that these constitute an array of drugs and drug-using subjects. By analysing the ways in which

authoritative discourses and practices come to shape how people constitute themselves and methamphetamine through day-to-day practices of consumption and service provision, I make visible the politics of ontology — that is, the open and contested nature of reality (Mol, 1999).

Theories that assume the ontological contingency of realities have rarely been applied to the area of methamphetamine use or its related harm reduction/treatment practices, yet this is an area that deserves critical attention. Current ways of constituting methamphetamine and methamphetamine users are highly pejorative, leading to the stigmatisation and marginalisation of people who use drugs. My work is important because it illuminates the political nature of the dominant understandings of methamphetamine and methamphetamine consumers, and because it suggests that are alternative ways of understanding this drug and those who use it. In doing so, it contributes to and extends upon a body of critical drug literature that seeks to provide a nuanced and complex understanding of drug use (see, for example, Duff, 2014; Dwyer & Moore, 2013; Fraser & Moore, 2011; Keane, 2004; Moore & Fraser, 2006; valentine, 2007). In this chapter I introduce the way methamphetamine use is understood in Australia, the methods and key theoretical concepts I have used in my research, and the central themes of my thesis. I also outline how the thesis will proceed.

## **Methamphetamine use in Australia**

Methamphetamine is classed as a central nervous stimulant (CNS) and as belonging to the series of drugs known as the amphetamines (Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2000). It is produced in various forms — including crystal methamphetamine (also known as ‘ice’), powder, ‘base’<sup>1</sup> and tablets — and can be consumed in several ways, such as injecting, snorting, drinking or eating and smoking. Methamphetamine was first synthesised in the 1890s and has been legally available in pharmaceutical preparations in the past (Anglin et al., 2000). It was reportedly provided to Japanese, German and US military personnel during World War 2 in order to improve performance, and was sold as an over-the-counter stimulant in Japan in the 1940s (Anglin et al., 2000). Currently, however, this drug is mostly used illegally, with very few countries allowing its legal manufacture or prescription. Globally, methamphetamine is considered a drug of concern, and trends relating to its production, traffic and use feature in the *World Drug Report* (United Nations Office on Drugs and Crime, 2013). The 2013 report finds that while ‘traditional markets’ such as North

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<sup>1</sup> ‘Base’ is a term used to refer to methamphetamine in the form of a sticky, damp powder.



America and Oceania (including Australia) have remained stable with regards to this drug's use, increased use and production has been reported in South East Asia, the Middle East and parts of Africa (United Nations Office on Drugs and Crime, 2013, p. xi). The report also states that Australia has a 'high' rate of methamphetamine use at 2.1% of the population (in 2010) (United Nations Office on Drugs and Crime, 2013, p. 2).

Significant use of methamphetamine was first reported in Australia in the 1990s (Australian Crime Commission, 2001). Up until this time, amphetamine sulphate was reported to be the most commonly used illicit stimulant in Australia (Australian Crime Commission, 2001). The shift from one formulation of amphetamine to another has been attributed to several developments. These include legislative changes in the 1990s that curtailed the availability of precursor drugs needed to manufacture amphetamine sulphate, and increased importation of methamphetamine from areas such as South East Asia (Australian Crime Commission, 2001). The 2013 National Drug Strategy Household Survey provides the most recent population-level data concerning the use of methamphetamine. This study reports that 7.0% of the Australian population aged 14 years and over, have ever used this drug (Australian Institute of Health and Welfare, 2014).<sup>2</sup> The study also reports that in the 12 months prior to 2013, 2.1% of people in Australia used meth/amphetamine, which is the same as in 2010 (Australian Institute of Health and Welfare, 2014). However, while there was no significant change in meth/amphetamine use between 2010 and 2013, different forms of this drug were used. Among people who had used meth/amphetamine in the previous 12 months, the proportion reporting use of powder decreased significantly from 51% in 2010 to 29% in 2013, while the prevalence of use of ice (or crystal methamphetamine) increased from 22% in 2010 to 50% in 2013 (Australian Institute of Health and Welfare, 2014). There are also national data concerning engagement in treatment due to meth/amphetamine use. These data report 'treatment episodes', where one treatment episode represents a completed course of treatment. Treatment episodes in which methamphetamine or other illicit stimulants was the primary drug of concern increased from 7% of all episodes during 2009-2010 to 14% during 2012-2013 (Australian Institute of Health and Welfare, 2011). These data are limited in what they can tell us about illicit drug use (Dwyer & Moore, 2010b), however, they suggest that a

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<sup>2</sup> Both the National Drug Strategy Household Survey and the National Minimum Data Set for alcohol and other drug treatment services report on 'meth/amphetamine'. As methamphetamine is reportedly the most common form of illicit stimulant in Australia, presumably the figures mostly relate to methamphetamine – rather than other amphetamines. Nonetheless, in order to report these data I use the term 'meth/amphetamine'.

substantial number of Australians have consumed this drug, with some accessing treatment services as a result.

While methamphetamine use was identified in Australia in the 1990s, it emerged as a serious problem in the early 2000s (Australian Crime Commission, 2001). This occurred after the interruption to Australian heroin supply that began in early 2001 and had a dramatic effect on Australia's illicit drug markets. Prior to 2001, high rates of heroin use and related harms such as overdose were key public health concerns; however, as heroin became less accessible, the number of overdoses related to the drug fell (Deitze & Fitzgerald, 2002). At the same time methamphetamine use was estimated to have increased and, since 2001, the availability, use and harms of methamphetamine have become major public issues, as demonstrated by extensive media attention (see, for example, Baker & McKenzie, 2013a; Bartlett, 2006; Carney, 2006; Hayes, 2006), parliamentary inquiries (see, for example, Drugs and Crime Prevention Committee, 2004; Law Reform, Drugs and Crime Prevention Committee, 2013), a national leadership summit (held in Sydney in December, 2006) and policy development (see, for example, Australian National Council on Drugs, 2007, Ministerial Council on Drug Strategy, 2008).

With increasing attention to methamphetamine in the arenas of government, science and media has come a proliferation of knowledge around this drug. Scientific research produces 'evidence' about methamphetamine. Policy determines which 'evidence-based' strategies are best used to address methamphetamine (Ministerial Council on Drug Strategy, 2008).

Treatment manuals outline 'best practice' for workers dealing with people who use methamphetamine (Jenner & Lee, 2008; Smout, 2008). The media produces reports on the harms of this drug, often focusing on its crystalline form, ice (Baker & McKenzie, 2013a). These fields of knowledge, or discourses, do not emerge in isolation from each other; rather, they are always mutually constitutive of each other. Highly authoritative, they constitute the 'truth' of methamphetamine — generating a broad understanding of methamphetamine as a highly destructive and dangerous drug, and methamphetamine users as psychotic and violent.

### **The specificity of methamphetamine and methamphetamine-using subjects**

In this thesis I address the attention given to methamphetamine use by critically analysing scientific, policy, treatment and media discourse. I argue that there is specificity to the ways in which methamphetamine and methamphetamine users are constituted, where

methamphetamine use and its purported effects is considered uniquely problematic. Analysing scientific texts, I contend that the materiality of methamphetamine is inscribed by the limited ways we can understand drug use. I also argue these texts constitute methamphetamine as a specifically destructive drug. Attending to policy, treatment and media texts, I investigate the constitution of methamphetamine-using subjects. I argue that these drug-using subjects are constituted in very specific ways, informed by broad understandings of the neo-liberal subject where free choice is valorised and compulsive activity such as drug use is abhorred.

In illuminating the specificity of how methamphetamine and methamphetamine users are constituted in dominant discourse, I argue that these are insufficiently sophisticated ways of understanding individuals and methamphetamine use. They also have political effects such as stigmatisation and marginalisation. To demonstrate their inadequacies and their effects, I present accounts of methamphetamine use and methamphetamine-related treatment practices, showing how individuals draw on hegemonic understandings of drug use while, at the same time, their drug-related practices subvert and reject these. This exercise reveals the contested nature of realities and the politics of ontology with respect to the drug methamphetamine.

### **Methodological approach**

My research involved two methodological stages. First, I analysed scientific, policy, treatment and media texts. Second, I conducted in-depth interviews with people who used methamphetamine and with service providers of harm reduction/treatment for methamphetamine use. To analyse texts related to methamphetamine I searched academic and ‘grey’ literature. For the purposes of my argument, I separated texts. I examined the object ‘methamphetamine’ through scientific texts (see Appendix A), and methamphetamine-using subjects through policy, treatment and media texts. This separation was artificial, as these texts emerge from discourses that are interlinked — produced by, and productive of, each other. However, sorting texts into these categories was a useful heuristic device and enabled to me to make a clear argument concerning the construction of both methamphetamine and methamphetamine-using subjects.

In addition to exploring and critiquing methamphetamine-related discourse, I also describe practices related to methamphetamine use. I do this through analysis of interviews with people who use methamphetamine and people who provide treatment services to methamphetamine users. I interviewed people who used methamphetamine; some were in

contact with alcohol and other drug (AOD) harm reduction or treatment services ('service users') and others were not ('non-service users'). Service users had accessed a service in the 30 days prior to the interview, and non-service users had not accessed a service in the six months prior to the interview. Interviews focused on participants' experiences of using methamphetamine and accessing services to address their methamphetamine use. These accounts of methamphetamine consumption and service encounters provide insight into how people incorporate methamphetamine into their lives, as well as the lived effects of this drug — pleasurable, harmful, or utilitarian.

I also interviewed practitioners from organisations that provide services to address methamphetamine use. Participants were recruited to ensure variation in service roles, with differing levels of responsibility. I interviewed service providers to investigate treatment practices particularly related to methamphetamine. Accounts of practice show the various ways in which services address methamphetamine use and drug use more generally. They also show the wide range of needs of people accessing AOD services. These accounts illuminate some of the ways in which people draw upon dominant discourses and, in presenting them, I aim to show the way hegemonic ideals of the ideal citizen and 'choice' shape the ways in which we can address drug use and understand drug users.

During interviews, and immediately after, I took field notes. These described the contexts of the interviews, including treatment and other services. I used these to give insight into the interview 'space' and how this might shape the accounts provided. Thus, my data collection involved texts, interviews and field notes.

### **Key theoretical concepts**

To attend to the body of knowledge developed around methamphetamine and the accounts of use and treatment of this drug, I draw on the related theories of post-structuralism and STS. Post-structuralism is an area of theory that has its origins in the 1960s in France and in which two scholars, Gilles Deleuze and Michel Foucault, are prominent. More recently, STS has emerged within post-structuralism, building upon the work of Deleuze and Foucault. Scholars in these areas provide working concepts that enable the interrogation of what is considered to be the 'truth' about methamphetamine, and argue that knowledge is always political. That is, 'truth' is not a transparent reflection of the natural world; it is constituted through power relations, institutions and rhetoric. Moreover, there are conditions necessary for producing 'truth', and new knowledge must be congruent with broader understandings of the world.

### **The contingency and political nature of truth/facts**

I employ theoretical concepts from the fields of post-structuralism and STS to scrutinise the ‘facts’ of methamphetamine use and describe the political and ontological effects of knowledge — how these facts shape the lived experience of people using methamphetamine. Using theoretical ‘tools’ from STS scholars Bruno Latour, John Law and Annemarie Mol, I challenge the ‘truth’ of methamphetamine by interrogating methamphetamine ‘facts’. Latour (2004) argues that ‘facts’ are political and limited representations of reality. He urges researchers to approach the world as a ‘matter of concern’ (Latour, 2004). This is not necessarily to dispute facts but to expand upon them, making visible their political nature, as well as other possibilities. Writing with Steve Woolgar, Latour argues that scientific practice is craft work, and that this work inscribes materiality in particular ways (Latour & Woolgar, 1986). In the case of methamphetamine-related science, the materiality of methamphetamine is inscribed as specifically potent and dangerous. It is a ‘hyper’ stimulant (Topp et al., 2002a) and its users are, among other things, violent and psychotic (McKetin et al., 2014; McKetin et al., 2006b). This body of work thus features descriptions of methamphetamine’s toxicity (see, for example, Shoblock, Sullivan, Maisonneuve, & Glick, 2003). It concerns itself with describing the characteristics of methamphetamine-using subjects; the harm they experience, the predictors of this harm, treatment outcomes and predictors of treatment outcomes (see, for example, Darke et al., 2008; Rawson, Gonzales, & Brethen, 2002). I scrutinise the scientific literature, making visible political acts of ‘choice’ and showing how methamphetamine has been enacted in the literature. I argue that the resulting ‘facts’ of methamphetamine are shaped by dominant ideas about drug use (such as ‘all drug users are pathologised and in need of treatment’). Moreover, I suggest that the facts of methamphetamine are contingent and, with my research, I intend to make visible other possibilities and ways of thinking about this drug.

### **Multiplicity and the conditions of possibility**

Expanding on my argument that scientific knowledge is contingent, I use the work of post-structuralist and STS scholars to demonstrate the multiplicity and ontological politics of reality. A key insight of Mol and Law is that all practice is ongoing, continually enacting reality; thus reality is multiple, constituted through an array of practices. This reinforces the contingency of knowledge and, most importantly, it opens up other ways of understanding drug use — making possible other, less oppressive, realities. At the same time these scholars acknowledge that not all realities are possible. This brings to light the contested nature of

realities, or ‘ontological politics’ (Mol, 1999). Practices are always shaped by broader forces and while multiple realities are possible they will have a common thread. This is the broader cultural forces at work and the current ‘conditions of possibility’ or ‘episteme’ that make various statements about methamphetamine present and repress others.

Mol and Law draw upon the work of Foucault in asserting that realities are shaped by broader forces. Foucault (1978) shows how power and control operate in modern societies, describing the current conditions of possibility and theorising the episteme. To address the nature of power, Foucault conceptualises ‘discourse’ as an array of practices, language and concepts that was productive of what could be said, thought and done about a given issue. Dominant discourses, such as public health, make possible the ways in which we can understand ourselves and others (Petersen & Lupton, 1996). In this way, power is exercised over individuals as they shape themselves according to these dominant understandings. Moreover, discourses themselves are shaped, and exist within, broader overarching societal norms. This is what Foucault terms the ‘episteme’ or the current conditions of possibility (Foucault, 1972, p. 191). These ideas allow me to demonstrate the local and specific ways in which methamphetamine and methamphetamine users are constituted, as well as provide insight into broader forces that shape these practices.

### **The subject and location of agency**

Central to the modern neo-liberal episteme is the autonomous, unitary subject. I use the work of Foucault and Nikolas Rose (who builds upon Foucault’s work) to better understand the self-governance and obligations of this subject. These scholars show how human agency is produced and valorised within the current conditions of possibility — understood as an attribute of the ideal citizen. Rose (1999) argues that modern citizens are defined through the choices they make and that uncompromised agency is essential to making these choices. Drug use (and addiction) compromises the ability to make choices, as it implies a compulsive act; it is not a free or ‘pure’ choice (Sedgwick, 1992, p. 586). Due to their compromised agency, drug users and ‘addicts’ are non-citizens, failing in their obligation to make the ‘right’ choices. I apply this understanding of agency to my data. I argue that the methamphetamine-using subjectivities made available by dominant discourses are in binary opposition. On the one hand, a highly active and self-controlled subject is produced in specific discourses. On the other, a subjectivity with compromised agency — an anxious, depressed, violent and chaotic methamphetamine user — is produced. Thus, these subjectivities are enacted in binaries such as controlled/chaotic or voluntary/compulsive. While this insight has been

applied to drug use and addiction previously (see, for example, Fraser & Moore, 2008; Sedgwick, 1992; Sear & Fraser, 2010a), there is specificity in the way we understand methamphetamine-using subjects. These subjects are understood in ‘extreme’ absolutes: they are hyper-controlled and, at the same time, hyper-chaotic. I explain these forms of subjectivity in terms of the current conditions of possibility. I also describe their ontological implications. I do this by examining the ways in which people who use methamphetamine, and people who treat methamphetamine use, draw upon these dominant understandings — but also how individuals resist or subvert dominant discourses.

### **Assemblages and becomings: An alternative conceptualisation of agency**

To understand methamphetamine-using subjectivities in a way that moves beyond the current binaries that underpin drug use, I seek alternative ways of conceptualising agency. To do so, I use the work of Deleuze and STS scholars. These scholars focus on the relationality of humans and non-humans. They conceive of the social and material as always constitutive of each other, rather than as separate entities. This way of thinking takes into account the expressivity (although not intent) of both human and non-human formations, considering how they shape and constitute each other. Approaching the world in this way involves a material—semiotic method. This treats:

everything in the social and natural worlds as a continuously generated effect of webs of relation within which they are located (Law, 2009).

The concept ‘webs of relation’ draws upon the Deleuzian term ‘assemblage’ (Deleuze & Guattari, 1987). ‘Assemblage’ captures the idea of the co-constitution of humans and non-humans, where matter and life forms — what we experience as reality — emerge from the same source. This source was conceptualised by Deleuze and Guattari as the ‘plane of immanence’ (1987, p. 266). Assemblages are networks that incorporate myriad heterogeneous elements and phenomena — the temporal, spatial, social and environmental — of objects and subjects. From these, subjectivities, objects and other entities emerge in moments of ‘becoming’. This is where we recognise matter and life forms as inscribed in a particular way — a drug user, a drug — but it is not a reified state. Emerging from the plane of immanence, humans and non-humans are continually in states of becoming.

The concept of assemblages, or a material—semiotic approach, acknowledges the dynamic and shifting nature of the world. In terms of methamphetamine consumption, this approach enables the consideration of the way spatial and temporal elements shape drug use, along

with the many objects (such as the drug, the utensils required to consume the drug) and subjects (such as drug users, drug dealers, police, family and friends) involved in this practice. In terms of harm reduction and/or treatment, the places and spaces of service provision, as well as the objects of service provision including diagnostic tools, pharmaceuticals and treatment plans, and harm reduction/treatment practitioners and clients, are seen as mutually constitutive of these encounters. Further, these encounters are productive of 'becomings'. This implies a dynamic reality, where multiple identities and 'things' are possible. For instance, a treatment assemblage may produce a body as a 'becoming' addict, whereas a family assemblage may constitute the same individual as a 'becoming' mother. Making use of these ideas in my research enables me to reject stigmatising and explanatory terms such as 'addict' and embrace a fragmented or multiple form of subjectivity, where people embody themselves in multiple ways.

Importantly, using 'assemblage thinking' (Duff, 2014, p. 633) allows me to move beyond orthodox accounts of agency and drug use. As I have noted above, agency is constructed in the modern episteme as located in the neo-liberal subject. Exercising agency in the correct way and making the right choices is the obligation of this subject. Failure to meet this obligation requires drug users to be categorised as 'failed' citizens and as responsible for their circumstances. Addressing drug use employing assemblage thinking makes possible a complex and nuanced reading of methamphetamine use. Rather than viewing methamphetamine use as the act of an individual with compromised agency (through sickness or deviance) it can be seen as constituted through assemblages of humans and 'things'. In this way agency is dispersed, and myriad phenomena contribute to the act of drug use. Moreover, assemblage thinking enables analyses of drug use that focus on the immediate connections and relationships that produce, and are productive of, drug-related practice (Duff, 2014). This way of thinking does not rely on structuralist concepts such as class or poverty to explain and describe methamphetamine-using practice. Through local description, however, the lived effects of social and economic marginalisation are made visible.

### **Ontological politics: What research makes visible**

The theoretical underpinning of my research rejects a singular and anterior reality. I use post-structuralist and STS thought to argue that reality is multiple, enacted through an array of practices. A Foucauldian understanding of the 'conditions of possibility' is illuminative of how these practices are limited and so too are the realities that can be 'made'. Using these theoretical tools has profound implications for research. Research is no longer the



investigation and revelation of a singular truth; rather, it is performative — a practice that enacts particular realities. Therefore, to address methamphetamine, I use Law's (2004) theory of method assemblage. This theory enables me to articulate the way in which research practice makes visible certain objects and subjects. Law argues that all research practice is a process of crafting 'presence, manifest absence and Otherness' (p. 42). Presence is what is made visible by the research. For instance, methamphetamine research may make present methamphetamine 'addicts' and methamphetamine itself as an addictive, dangerous substance. Research also makes things absent, and Law distinguishes between two types of absence: 'manifest absence' and 'otherness'. Manifest absence is that which presence acknowledges — that is, things that are necessary to the objects and subjects made present in research. For instance, if research constitutes methamphetamine as an addictive drug, criminal behaviour and treatment centres are manifestly absent. That is, they are absent in this account, but necessary to the presence of addiction. 'Otherness', however, is an absence that is not acknowledged. This is what is othered, excluded, ignored and even repressed in research. When methamphetamine addiction is made present, concepts such as pleasure are othered. Law's (2004) method assemblage is an approach to research that requires the researcher to remain cognisant of presence, manifest absence and otherness, and even to challenge the boundaries between these states.

Employing Law's (2004) concept of the method assemblage in my research allows me to challenge the 'evidence' that currently constitutes methamphetamine, making visible the ontological politics of this drug. That is, I acknowledge there are choices and power involved in 'making' reality — it is both contested and open (Mol, 1999). I show how highly authoritative discourses such as science, policy and treatment constitute methamphetamine in particular ways. The practices that emerge from these fields constitute methamphetamine as an anterior and stable substance with inherently toxic properties. Dominant accounts of this drug constitute users as both specifically violent and psychotic, and knowledgeable and self-aware. Using accounts of methamphetamine consumption and harm reduction/treatment practitioner accounts, I bring to light the political effects of these hegemonic enactments of methamphetamine as well as alternative enactments of methamphetamine use. I show how particular assemblages of drug use and service provision disrupt, draw upon or reject hegemonic enactments of methamphetamine and re-make methamphetamine and methamphetamine users in multiple ways. Further, I acknowledge that my research also draws boundaries between what is made present and what is 'othered'. Remaining mindful of

these distinctions, I use the theories I have outlined above to provide an alternative way of thinking about methamphetamine use, where pejorative understandings of the drug-using subject are rejected for a more complex exploration of the many elements involved in producing drug use and harm.

A corpus of research literature uses the theories I have outlined above to provide insights into drug use and complex and nuanced accounts of it (see, for example, Duff, 2014; Dwyer & Moore, 2013; Fraser, 2011). My research is unique, however, as it applies these theories to the practice of both methamphetamine consumption and related service delivery, including treatment and harm reduction. It breaks new ground in that it interrogates the science of methamphetamine using tools from STS, not seeking to debunk the ‘facts’ but to argue that these are contingent. My research also furthers the work of scholars that have investigated the subjectivity of drug users (Seear & Fraser, 2010a, 2010b; valentine, 2007) by analysing authoritative texts to illuminate the specificity of the methamphetamine user. More broadly, I extend previous qualitative accounts of methamphetamine and other drug use by foregrounding the ontological contingency of methamphetamine and of drug users. In doing so I move beyond accounts of drug use that assume there is a ‘true’ representation of drug issues and that drugs and drug users can be described accurately through scientific practice (Armstrong, 2007; Ayres & Jewkes, 2012; Jenkins, 1994). This research argues that all things are ontologically contingent and inherently political and, in seeking to describe the constitution of drugs and drug users, I aim to provide new ways of thinking about this drug that could contribute to more sophisticated ways of understanding methamphetamine use.

In order to address my research questions I first document the ways in which the materiality of methamphetamine has been inscribed in scientific texts. I then explore the materialisation of methamphetamine-using subjects in policy, treatment and media texts. Following this, methamphetamine-related consumption and harm reduction/treatment practices are described and their effects discussed.

### **How this research proceeds**

Chapter Two contains my review of the literature and positions my thesis in terms of sociological research concerning methamphetamine and, where relevant, other drugs. To address the sociological literature on methamphetamine, I assign this work to one of two categories. These are: (1) research that is underpinned by the assumptions of public health, biomedical and scientific discourses, and (2) research or commentary that critiques these

discourses. I first review qualitative literature that embraces the assumptions of public health, demonstrating how it increases the scrutiny of the methamphetamine-using subject. I argue that, while well-meaning, this sociological research has political effects. These include increasing scrutiny of the methamphetamine-using subject and contributing to its pathologisation by uncritically accepting terms such as ‘addict’. I then review a more critical body of work. I show how this literature addresses drug use without relying on concepts emerging from public health discourse such as ‘addiction’ and ‘abuse’. Instead, drug use is conceived of as a practice that constitutes and is constituted through networks of subjects, objects and spaces, rather than as singularly the actions of a pre-existing pathologised and/or transgressive subject. In this chapter I explain how my research extends upon this corpus, as it treats ‘reality’ as ontologically contingent, showing the ways in which dominant discourses such as public health come to bear upon the practices that constitute methamphetamine and methamphetamine consumers.

Chapter Three presents my theoretical and methodological framework. I set out the theoretical approach that I use in my research, presenting the key concepts I draw from the work of post-structuralist scholars Foucault and Deleuze and, more recently, Rose, and STS scholars Latour, Law and Mol. I explain how these concepts enable me to foreground practice, decentring the (addicted) subject. I also show how these concepts are useful in illuminating the ontological politics of methamphetamine use, allowing me to critique the status of current knowledge around methamphetamine and to challenge the very pejorative ways in which we currently understand people who consume this drug. I then present the methodological approach I use to undertake this research, one that is congruent with these theorists’ work: method assemblage. I explain the implications of using this approach, and its political commitment to produce realities that are less oppressive.

Chapter Four is my first data chapter, and its object of enquiry is the drug methamphetamine as it is materialised in scientific literature. In this chapter, I argue that scientific discourse enacts methamphetamine as uniquely problematic drug. I do this by focusing on texts that have originated from Australian scientific research, but also discussing some US-based research. I use theoretical concepts developed by Latour and Woolgar (1986) to argue that current knowledge around methamphetamine is contingent — the result of considerable scientific work as well as political choices. Tracing the constitution of methamphetamine in scientific texts makes visible the ontological politics of this substance, showing how existing concepts, practices and bodies of knowledge mean that there are limited ways we can ‘make’

methamphetamine. I argue that the reification of methamphetamine has political effects for people who use this drug, as they are seen as addicts and pathologised by knowing methamphetamine in this very singular way.

In Chapter Five I shift to analysis of policy, treatment and media texts in order to look at the ways in which the ‘facts’ of methamphetamine are taken up and reproduced in broader spheres. I examine methamphetamine-using subjects in these texts, finding that they are enacted in dualistic spheres — a series of ‘absolutes’ (Sedgwick, 1992). These include active, self-controlled and reflective subjects versus inactive, violent and chaotic subjects. This bifurcation is found in previous work that examines the way Western liberal societies understand drug use and addiction and is underpinned by the valorisation of choice and disgust of those subjects deemed to be driven by compulsion (see Keane, 2002; Sedgwick, 1992; Seear & Fraser, 2010a). I build upon this work and argue that there is specificity to the bifurcation of methamphetamine-using subjects; these subjects are enacted in ‘extreme’ absolutes. I examine the specific capacities of the subjects manifested in these dualistic spheres, noting tensions and slippages and illuminating the epistemic assumptions that are common to both. In bringing to light the capacities of methamphetamine-using bodies constituted in authoritative texts, I demonstrate the political nature of these enactments, and the limited ways in which we are able to understand the human subject and drug use in the current conditions of possibility.

In Chapter Six I move from discourse analysis to my interview data. I do so in order to describe how dominant understandings of methamphetamine-using subjects are both (re)produced and subverted in accounts of methamphetamine consumption — drawing attention to the ontological politics of drug-using bodies. Moreover, attending to the material—semiotic networks of drug use, I illuminate some of the ways in which these produce, and are produced by, controlled and/or chaotic bodies. I argue that active practices and attributes such as self-control are produced by the social, material and knowledge connections an individual has access to, rather than being an expression of an individual’s character. Likewise, feeling out of control, taken over by methamphetamine and other practices that suggest a lack of self-control emerge from the relations an individual can form, and the assemblages they are enmeshed within, rather than a deficiency of will. Thus, through my analysis of accounts, I show how both localised assemblages and broader understandings of drug use are intrinsic to ways in which individuals who use methamphetamine embody themselves.

In Chapter Seven I turn to the accounts of harm reduction and drug treatment practitioners in order to further scrutinise the dualistic ways in which we understand methamphetamine and methamphetamine users. As with previous chapters, I am concerned with illuminating the ontological politics of this particular practice. I show how dominant enactments of methamphetamine play out in the day-to-day activities of practitioners — how they are embraced and resisted, and the sets of tensions this may introduce for clients. My argument uses analyses of change to understand accounts of harm reduction/treatment practice. I trace this concept, examining how accounts of service provision enact change in conventional ways — as instigated by the drug-using subject, for instance — but also in less conventional ways, such as occurring by chance and mitigated by other encounters in the client's life. As with Chapter Six, I illuminate the ways in which the localised assemblages individuals are enmeshed within are productive of capacities and thus of the choices that are possible in terms of drug use and change.

Chapter Eight concludes my thesis. In this chapter I bring together the themes that I have explored in my research in order to make some concluding remarks concerning the ontological politics of methamphetamine and its consumers. I consolidate my argument about the very specific ways in which methamphetamine and methamphetamine users are constituted in dominant discourses. I also make some final comments concerning the contested and contingent nature of reality, re-visiting how individuals may embrace, resist or subvert these dominant enactments in their day-to-day lives. In my conclusion I suggest that by making visible alternative ways of constituting methamphetamine, I have illuminated other possibilities for addressing this drug and contributed to literature that seeks more nuanced and complex ways of understanding drug use.

## Chapter 2: Sociological accounts of methamphetamine; Sociology *for* and *of* public health

My research is a qualitative exploration of methamphetamine use and related service provision, drawing on post-structuralism and the field of STS. The following literature review of qualitative, sociological research concerning methamphetamine consumption maps the existing empirical literature and positions my research in relation to it. In this review I also present the particular area of research to which my work will contribute and extend upon, thus demonstrating its significance.

To address the sociological literature on methamphetamine, I first assign this work to one of two categories. These are: (1) research that is underpinned by the assumptions of public health, biomedical and scientific discourses, and (2) research or commentary that critiques these discourses. I base this distinction on Moore's (2004) delineation of a 'sociology *in*, or *for*, health policy, and a sociology *of* health policy' (p. 1547). He explains the differences and tensions between the two in the following way:

In the former, the aim is to employ sociological perspectives and methods in order to refine or improve health policy whereas, in the latter, health policy itself — its theories, methods and ideological bases — becomes the object of enquiry. Those engaged in the analyses of health policy criticise those engaged in applied research for their collusion in expert-driven social control. The refinements or improvements made to health policy are portrayed as little more than new forms of governmentality. Those engaged in more applied health research sometimes characterise the 'of' research as theoretically elegant but of little practical value. (Moore, 2004, pp. 1547-1548)

Using this classification, I examine qualitative methamphetamine research in terms of whether it contributes to a sociology *for* public health (and its associated discourses, such as biomedicine and science) or to a sociology *of* public health. I argue that, while well-meaning, qualitative research on methamphetamine that uncritically accepts the assumptions of public health has certain political effects. These include an increase in the surveillance of drug-using subjects through the construction of different 'cohorts' of drug users and 'deeper' experiences of 'addiction' and 'abuse' hitherto unexplored in research, and the reinforcement of the addiction/recovery binary that produces drug users as chronically pathological subjects, defined only by the practice of drug use.

My research will build upon a body of work that takes a more critical approach to public health discourse, acknowledging that this discourse is inseparable from other discourses such as biomedicine and science. This literature addresses drug use without relying on, or by criticising, concepts emerging from these discourses such as addiction, abuse and treatment. Instead, drug use is conceived as a practice that constitutes, and is constituted through, networks of discourses, subjects, objects and spaces, rather than as solely the action of a pre-existing pathological and/or transgressive subject. The assumption that drug use is inherently unhealthy, harmful or addictive is rejected, and the cultural significance and political effects of this practice are foregrounded. My research extends upon this corpus, as among its objects of enquiry are the concepts of addiction and treatment as well as the way in which methamphetamine has been reified through scientific discourse. Through the interrogation of these objects, and others, my research engages theoretically with the fields of post-structuralism and STS, demonstrating how these theories can illuminate our understanding of methamphetamine use and service provision. This is an area which, to date, has received little theoretical attention. In addition to its theoretical significance, my research has applied relevance. It describes the lived experiences of people who use methamphetamine in relation to dominant discourses, such as public health, showing the political effects of these discourses. It also describes harm reduction and treatment practices and the particular subjectivities these practices make available, demonstrating the limits of current ways of thinking about drug users. While I do not offer prescriptive advice to harm reduction and/or treatment services concerning methamphetamine use, I hope to contribute to alternative ways of thinking about people who use methamphetamine that may inform the services available to them.

This review proceeds as follows: first, qualitative research concerning methamphetamine that, I argue, contributes to a sociology *for* public health is reviewed. I then review a smaller body of qualitative research, as well as discourse and policy analyses, that contributes to a sociology *of* public health.

### **A sociology *for* public health**

A large body of qualitative research concerning methamphetamine originates in North America, but also from countries such as Thailand (German et al., 2006; Sherman et al., 2008) and New Zealand (Sheridan, Butler, & Wheeler, 2009). This work illuminates the ways in which culture, gender, economic status, race and other considerations come to bear on practices of methamphetamine consumption, enriching our understanding of the cultural and

social practices that produce drug use. Additionally, it personalises the experience of methamphetamine use, generating empathy and respect for people who use drugs (Keane, 2012). Yet, as a whole, this work contributes to a sociology *for* public health (Moore, 2004), uncritically accepting public health assumptions regarding illicit drug use. These include that drug use is invariably a risky, harmful and addictive activity. This body of qualitative research is extensive and so, for the purposes of this review, I do not address each article individually in this corpus. Instead, I make three points about this work generally, using individual articles to illustrate these observations. My observations are, first, that although aspiring to an in-depth and rich understanding of methamphetamine use through qualitative methods, this body of research embraces public health discourse. It analyses and presents data in very conventional ways, rather than providing insight or alternative ways of considering drug use. This means that this research then helps to materialise and reproduce hegemonic understandings of drug use. Second, this work generates cohorts or populations at risk of, or experiencing, methamphetamine-related harms, thus increasing the surveillance of methamphetamine-using subjects. Third, this research makes methamphetamine-using individuals liable to more intensive forms of investigation through in-depth methods. I now address each point in turn.

### **Interpreting data using public health concepts**

The corpus of methamphetamine research that I classify as a sociology *for* public health often mobilises concepts of public health such as addiction, drug-related harm and recovery.

Because these concepts are not critically addressed, they inform data interpretation in very conventional ways. They therefore lead to assumptions such as drug use inevitably leads to addiction which must then be resolved through recovery. Two articles that describe ‘trajectories’ of methamphetamine use (Boeri, Harbry, & Gibson, 2009; Sexton, Carlson, Leukefeld, & Booth, 2008b) exemplify this point. These articles, as with most in this particular corpus, are well-intentioned and present interesting data. Yet, they both embrace addiction as the primary way to describe patterns of methamphetamine use. This leads them to generating understandings of people who use methamphetamine as addicts in need of recovery.

Rocky Sexton, Robert Carlson, Carl Leukefeld and Brenda Booth (2008) studied the self-reported trajectories of methamphetamine use among rural populations in the US. When describing their analysis, the researchers state:



We identified three trajectories of MA [methamphetamine] use at follow-up: abstinence, reduced use, and continued use, with decreasing use and abstinence as dominant themes. (Sexton et al., 2008b, p. 8)

The use of the word ‘identified’ in this statement suggests that the authors consider these categories as pre-existing their data. It could be argued that rather than having identified these patterns of use, the researchers imposed them on their data in accordance with their understanding of methamphetamine as an addictive drug. This understanding is stated up front in the text as the authors describe methamphetamine as ‘an addictive CNS stimulant that causes short-term and long-term consequences’ (Sexton et al., 2008b, p. 1). Thus, rather than looking to their own data to illuminate practices and patterns of methamphetamine use, these authors inscribe pre-existing pathological categories onto participants’ methamphetamine consumption.

Miriam Williams Boeri, Liam Harbry and David Gibson (2009b) undertook research with ‘suburban’ users of methamphetamine. This study also considers its participants’ methamphetamine use in terms of addiction. The codes the authors use to describe drug use trajectories are ‘(a) initiation, (b) access, (c) turning points, (d) treatment, and (e) relapse’ (p. 4). The data presented within their text, however, suggest that methamphetamine consumption is more complex than these codes imply. For instance, the researchers find that methamphetamine use among their participants is sometimes driven by people’s ‘need to “function” rather than a desire to get “high”’ (Boeri et al., 2009b, p. 5). One participant who said that she often used methamphetamine at home while doing housework stipulated:

Personally, I never associated it with being high. At that point I was not doing enough to get the high, high feeling. (Boeri et al., 2009b, p. 6)

Other people reported using methamphetamine in order to ‘have the energy to maintain a normal suburban lifestyle’ (Boeri et al., 2009b, p. 6), and this involved completing mundane tasks such as housework or overtime at work. Yet, after presenting these data the authors explain:

Since methamphetamine affects dopamine neurotransmitters, the user feels euphoria while on the drug. (Boeri et al., 2009b, p. 7)

A state of euphoria seems counterintuitive to the instrumental use of methamphetamine in order to do housework or work long hours. Further, participants in this research explicitly stated they were *not* seeking to experience the possible euphoric effects of methamphetamine.

The above statement suggests that Boeri and colleagues rely on biomedical discourse to understand methamphetamine, rather than generating alternative understandings of this substance on the basis of their own data. This is unfortunate as their participants' use of methamphetamine to maintain 'normality' provides a counterpoint to the literature that suggests methamphetamine use is driven by aspects such as emotional abuse (O'Brien, Brecht, & Casey, 2008), and that it can result in violence (Baskin-Sommers & Sommers, 2006; Sommers & Baskin, 2006) and severe harm (Darke et al., 2008).

The two articles I have reviewed above are characteristic of this particular body of literature and suggest that embracing the concepts of public health leads to understandings of methamphetamine—using subjectivities as pathological and addicted and methamphetamine as a singularly harmful and addictive substance. Moreover, as I will show in the following sections, embracing public health discourse and positioning data in terms of addiction and recovery have political ramifications. Most notably, they have the effect of making people who use drugs visible as objects of intervention and treatment. This legitimises their increased surveillance, both more broadly as 'populations' of drug users, and individually as the 'inner' drug user is scrutinised through qualitative methods.

### **Increasing surveillance of methamphetamine-using cohorts**

The second point I make about the body of qualitative methamphetamine research I classify as a sociology *for* public health is that it identifies specific cohorts or populations of methamphetamine users, highlighting the previously unknown consumption practices of these subjects, with the specific aim of contributing to interventions such as clinical practice. New populations suitable for investigation and intervention in this body of work include: gay men (Diaz, Heckert, & Sánchez 2005), HIV positive gay and bisexual men (Reback & Grella, 1999), mothers (Haight, Carter-Black, & Sheridan, 2009), parents (Haight et al., 2005) functional users (Lende, Leonard, Sterk, & Elifson, 2007), people in the rural south of the US (Sexton, Carlson, Leukefeld, & Booth, 2008a; Sexton et al., 2008b; Sexton, Carlson, Leukefeld, & Booth, 2009), African American people in the rural south (Sexton et al., 2005), suburban dwellers (Boeri et al., 2009b; Boshears, Boeri, & Harbry, 2011), women suburban dwellers (Boeri, Tyndall, & Woodall, 2011), 'baby boomers' (Boeri, Sterk, & Elifson, 2006), adolescent girls (Newbury & Hoskins, 2008, 2010a, 2010b, 2010c), 'street youth' (Bungay et al., 2006), Native American and White youth in Appalachia (Brown, 2010) and people living in Appalachian Tennessee (Macmaster, Tripp, & Argo, 2008). Each cohort in this extensive list is argued to require investigation although, as I show later, some of these justifications are

tenuous. I now look at three examples of literature that concern specific cohorts in order to outline how the particular populations are constructed with the intent to intervene in them.

Wendy Haight, Janet Carter Black and Kathryn Sheridan (2009) research mothers who use methamphetamine, arguing this is necessary due to the increase in women of child-bearing age using methamphetamine and the neglect experienced by children whose parents use methamphetamine. The authors also claim:

Not surprisingly, the abuse of methamphetamine is taking a serious toll on the child welfare system (Zernicke, 2005), and many child welfare officials report an increase in the number of children entering foster care because of parent methamphetamine abuse, especially on the West Coast and in rural areas (Zernicke, 2005). (Haight et al., 2009, p. 71)

Here, methamphetamine use is explicitly linked to child neglect and strains on the welfare system. This then justifies research into the use of methamphetamine by mothers. The citation used in this statement, Zernike (2005), is a *New York Times* article entitled 'A drug scourge creates its own form of orphan'. In it, anonymous 'officials' are quoted liberally, linking children in need to increasing parental methamphetamine use. As a mainstream media text, it is not a credible source upon which to base an academic argument. Its use demonstrates the somewhat shaky foundations upon which the justifications for researching particular cohorts can be built.

That said, the use of drugs by people who care for children is an area worthy of research. This group is highly stigmatised, and qualitative research could contribute to a better understanding of these individuals' circumstances, perhaps challenging stigma. Indeed, this is one of the objectives of Haight and colleagues' (2009) article, as they speculate:

Understanding mothers' experience of methamphetamine addiction can increase our awareness of this illness, reducing stigma and suggesting strategies for engaging them in intervention. (p. 71)

Yet, while the authors' stated aim is to reduce stereotyping and stigma, a critical gaze is not applied to the concept of addiction itself. This concept is part of a broader discourse that positions people who use methamphetamine as disorderly, unwell and unable to carry out their societal roles (such as parenthood). Haight and colleagues' introduction, with its focus on children's neglect and overloaded child protection services, flags these assumptions. This research, therefore, while aiming to address discrimination directed at women with children

who use methamphetamine, is unable to move beyond conventional (and stigmatising) ideas of drug use and offer an alternative narrative concerning mothers and methamphetamine use.

In another article concerning a specific cohort — people who live in the suburbs — Boeri and colleagues (2009b) conduct interviews with 48 former and current methamphetamine users about their ‘drug careers’ (p. 139). To justify their research with this population, the authors state:

Methamphetamine users living in the suburbs comprise a hidden population of hard-to-reach individuals. We know very little about the mechanisms of initiation or patterns of methamphetamine use among this under researched population. (Boeri et al., 2009b, p. 139)

It is difficult to see how people who use methamphetamine who live in the suburbs might be a ‘hidden population’ more so than any other group of drug users. And establishing this group as a specific ‘population’ with particular ‘mechanisms of initiation’ and patterns of use is a tenuous proposition, given the sheer number and heterogeneity of suburban dwellers. Nonetheless, in this research, these attributes qualify these individuals as a specific research cohort. I have discussed the findings of this research in the previous section, but here draw attention to the way the authors position their findings solely in terms of intervention:

Through this qualitative inquiry into suburban settings, we have a better understanding of the diverse trajectories in methamphetamine use that can help us develop and implement more focused treatment, intervention, and prevention programs. (Boeri et al., 2009b, p. 14)

The use of the term ‘focused’ in the statement above suggests that, as a result of this research, greater scrutiny may come to bear on those who use methamphetamine. In this sense, by constructing suburban dwellers as a specific cohort of methamphetamine users, these people are remade as legitimate objects of surveillance and intervention.

The final example I give of a particular methamphetamine-using cohort being established through research is an article published in 2007 by Daniel Lende, Terri Leonard, Claire Sterk and Kirk Elifson (2007). The article presents research with ‘functional users’; that is, people who use methamphetamine in order to enhance their ability to function at work or socially. In this research, 40 participants were interviewed and it was found that methamphetamine enhanced aspects of their lives, including work and socialising. Participants mentioned numerous benefits to methamphetamine use such as improved eyesight, improved ability to

study, and additional stability in their lives. Generally, people who took part in this research emphasised the positive effects of methamphetamine use — not a particularly surprising outcome as this group of people deliberately used methamphetamine to improve their ‘functionality’. As a group, such individuals would not seem to be obvious candidates for treatment or intervention. Despite this, the findings of this research are positioned in terms of their relevance to interventions. As Lende and colleagues (2007) conclude:

Functional use can help expand theories of self-medication and motivation/expectancy which have focused on internal feeling states. Not only will this expand our understanding of why people use drugs, it should help in developing more appropriate interventions for treatment, prevention, and harm reduction. (p. 475)

This finding does not do justice to the more thoughtful exploration of data in the article itself, where the idea of functional drug use and what this means to people who use methamphetamine is elaborated on. The data challenge assumptions concerning methamphetamine, showing people use the drug to improve work practices, to appear ‘straight’ and feel in control. Ultimately, however, the data are positioned as pointing the way to new interventions — including treatment. In this way, another population of drug users is legitimised as the object of surveillance.

In summary, a significant body of qualitative methamphetamine research concerns particular cohorts of users. This work offers insight into the ways in which specific cultural, economic and environmental settings shape methamphetamine use. However, the findings of research are consistently positioned in terms of their relevance to public health objectives (such as intervention and/or treatment), with concepts such as recovery and addiction accepted uncritically. Because of this, this work contributes to a sociology *for* public health. Further, these cohorts are always considered to be at risk of, or experiencing, drug-related harm. Considered in this way, documenting the practices of specific populations materialises an escalating number of drug-using subjects suitable for investigation and intervention, increasing the surveillance of individuals who use methamphetamine.

### **Investigating the subject: Qualitative forms of investigation**

As well as identifying and researching particular cohorts of methamphetamine users, some texts within the body of qualitative methamphetamine research that is classified as a sociology *for* public health purport to reveal hitherto unexplored dimensions of methamphetamine users’ subjectivity and/or their experience of abuse and addiction. In these

texts, qualitative methods such as in-depth interviews are assumed to result in a more profound understanding of people who use drugs. However, I argue that because this literature uniformly presents data in relation to interventions such as treatment and does not critically assess terms such as addiction, these methods also become tools to enable surveillance of the inner methamphetamine user. While in the previous section I showed how specific populations are made visible as objects of research, in this section I show how individual methamphetamine users are made visible as objects of intense scrutiny, such that their inner selves and experiences are constituted as legitimate objects of research. To do so, I first review an article that attempts to reveal the inner meanings of methamphetamine use (O'Brien et al., 2008) and then a series of articles on adolescent girls who use methamphetamine in Canada (Newbury & Hoskins, 2008, 2010a, 2010b, 2010c).

In a paper published in 2008, Ann O'Brien, Mary-Lynn Brecht, and Conerly Casey present 'narratives of methamphetamine abuse'. The paper is the result of research with 300 people using methamphetamine, none of whom had accessed formal treatment programs. The aim of the article is to discuss 'the meanings of MA abuse from the users' perspectives' (p. 345), and to describe 'the development of MA abuse' (p. 345). The authors argue that this will lead to 'an understanding of the inner experiences of MA users' (O'Brien et al., 2008, p. 345) and that the paper 'illuminates the emotional experience of MA abuse' (O'Brien et al., 2008, p. 363). Although purportedly revealing an in-depth understanding of methamphetamine use, the authors employ the language of addiction and abuse uncritically throughout the article, presenting methamphetamine use as it is produced through public health discourse. The fundamental finding of this piece of research is 'the development of problematic MA use across the lifespan' (p. 362). Here, the authors link methamphetamine use to experiences such as child abuse and treat it as an 'escape' (p. 362). This is a typical narrative of 'damaged' and 'traumatised' drug users, linking drug use to poverty and abuse (valentine & Fraser, 2008). This familiar trope can be useful in mobilising empathy and advocating for people who use drugs (valentine & Fraser, 2008). It is, however, a standard interpretation of data and shows that the deployment of qualitative methods has not led to new insights into methamphetamine use in the case of this research.

Employing public health assumptions to frame their analysis, O'Brien and colleagues (2008) position their conclusions explicitly for the purposes of enhancing treatment. The authors find:

Because qualitative research can illuminate the meaning of MA abuse to individual users, which clinicians can then incorporate into their treatment, it allows a direct link between research and treatment. (p. 364)

Producing research that can contribute to knowledge that informs methamphetamine-related practices is of great importance. Yet, in this case, the revelations of qualitative research are linked solely to treatment interventions, with the concept of treatment itself given no critical attention. If the purpose of revealing the inner experiences of methamphetamine users is to inform treatment interventions into their lives — rather than to challenge conventional and pejorative constructions of drug use and users — then greater scrutiny is brought to bear on methamphetamine-using subjects. Their thoughts and feelings are investigated in order to ascertain how and why they are ‘deficient’ subjects (abusers of methamphetamine). It also reinforces narrow conceptions of what drug use is, and limits the research’s capacity to generate original insights.

Janet Newbury and Marie Hoskins (2008, 2010a, 2010b, 2010c) author a series of articles that present qualitative research with young women using methamphetamine. This work aims to contribute to a ‘meaningful’ understanding of drug users (Newbury & Hoskins, 2008, p. 227). However, it uses addiction to understand drug use, contributing to conventional understandings of the experiences of these young women and the young women themselves. These researchers studied young Canadian women who used crystal methamphetamine, with an innovative research method called ‘photovoice’ (Newbury & Hoskins, 2008, p. 232). They assert that by using qualitative methods they ‘tap into nuanced, contextualized, and socially constituted aspects of...participants’ experiences’ (Newbury & Hoskins, 2010b, p. 18). This research project appears to ask a great deal of participants. They are given cameras and asked to take a series of photographs, respond to two sets of questions, as well as keep a journal. They are then interviewed about these images, an exercise the researchers refer to as ‘research conversations’ (Newbury & Hoskins, 2010c, p. 171). During the interviews the young women discuss their drug use and their feelings about themselves. For instance, one participant (Tara) says of herself:

It’s just how I am. Even though I know I can do anything I want, I always feel pieces missing. Like, there’s a piece of my life that I’ll never get back. (Newbury & Hoskins, 2010c, p. 168)

This statement demonstrates the personal and revealing nature of the research, as Tara openly talks about the impact of drug use on her sense of self and her life.

By collecting this personal and in-depth information, the authors aim to ‘reconceptualise clinical practice’. This is a worthy aim, but it is not done in a way that challenges the idea that their participants are struggling with addiction (Newbury & Hoskins, 2010c, p. 167). While the authors commit to a social constructionist stance, they are unable to consider addiction itself as socially constructed. This is demonstrated in the following statement:

A social constructionist approach to addiction involves broadening our scope to include the lived experiences of those who are addicted to substances, including but not limited to the experience of addiction itself. (Newbury & Hoskins, 2008, p. 230)

Here, a key idea of social constructionism — that knowledge is constructed through forces such as discourse and power — is not extended to the concept of addiction. And because the authors never critically attend to addiction, data are consistently explained in terms of this concept, and its binary opposite — recovery. This leads to conclusions such as the following:

[A]ll of our participants indicated that feeling supported by friends and family, being permitted to ‘regress’ from time to time, witnessing ‘success stories’ around them of acquaintances who overcame drug dependency, developing skills and capacities, finding alternative expressive outlets, and experience [sic] a sense of growth in their own lives are all factors that led to both the desirability and possibility of recovery. (Newbury & Hoskins, 2010a, p. 648)

With this statement the researchers suggest that drug use is a multiple and complex experience, of which the individual is just one part. But the focus is simultaneously on recovery, requiring that we consider the drug user as ‘sick’ and drug use itself as a ‘disease’. These are assumptions embedded within public health discourse and ones that consider drug use as the practice of a pathologised subject, othering the complexity of this practice.

While Newbury and Hoskins (2008, 2010a, 2010b, 2010c) aim to provide new insights into young women’s methamphetamine use, and change clinical practice in this area by using qualitative methods, their research falls short. Their methods investigate the experiences and feelings of participants, rather than interrogating (and hence questioning) some of the dominant concepts offered up by public health discourse such as craving and addiction. Because the research findings are couched solely in terms of recovery, the data collected do not lead to more profound or meaningful understandings of people who use methamphetamine. Instead, these data reiterate conventional narratives of addiction and recovery. Moreover, as I argue above, collecting data primarily to find better ways to ‘cure’



people who use drugs makes participants visible as objects of intervention. That is, people using methamphetamine are uniformly considered as addicted or at risk of addiction and are therefore pathological subjects. By using qualitative research methods such as in-depth interviews, the intimate experiences and feelings of methamphetamine-using subjects are revealed and scrutinised. In this way, as previously noted, surveillance of the individual subject can be intensified through qualitative methods.

To sum up, many of the articles in this body of qualitative work demonstrate the cultural shaping of drug practices, perhaps creating more empathy and respect for people who use drugs. That said, making drug users visible is a political exercise and none of the researchers presented here acknowledge this (Keane, 2011). If drug users are made visible only in order to develop treatment and intervention responses, this has the effect of increasing surveillance of drug users themselves, and produces and reinforces methamphetamine consumption as a pathological and/or deviant practice, congruent with bio-medical and public health literature (see, for example, Darke et al., 2008; Rawson et al., 2002). It makes drug users the central point of intervention for addressing problematic drug use (Keane, 2011). It also feeds stigma and discrimination by reproducing assumptions and stereotypes. My work challenges these insufficiently sophisticated ways of thinking about methamphetamine. It does this by shifting focus from the drug user as the object of investigation to understanding drug use as a practice that involves myriad phenomena, including people who use drugs, the drugs themselves and physical and social spaces of consumption. Further, it interrogates, rather than embraces, concepts such as addiction and trauma. It does not seek to investigate the truth of methamphetamine use, seeing it as driven by these concepts, but argues there are multiple experiences of use. At the same time, I trace dominant understandings of methamphetamine use and consumers in order to show how these shape methamphetamine-related practices. While my research makes methamphetamine users visible, I aim to do so in a way that does not reproduce them as pathologised, violent and psychotic, but that shows the complexities of drug use, challenging the idea that drug use is inherently harmful and addictive.

### **A sociology of public health**

I now review methamphetamine and other drug literature that contribute to a sociology of public health. Rather than accepting public health concepts such as addiction and abuse, this body of work critiques these concepts. It does so through the use of theory that can challenge the accepted truths of public health. In this section I review methamphetamine-related literature in order to show how this work extends and challenges common assumptions about

drugs. I also review some key pieces of other drug research that draw on similar theoretical concepts to my research. I do so in order to position my work and show how it contributes to a sociology *of* public health.

### **Critical accounts of methamphetamine use**

First, I review five qualitative accounts of methamphetamine use (Duff, 2014; Dwyer & Moore, 2013; Green & Moore, 2013; Slavin, 2004a, 2004b). While there are older qualitative accounts of stimulant use, these address amphetamine use (see, for example, Boys, Fountain, Griffiths, Stillwell, & Strang, 1999; Carey & Mandel, 1968). As my work focuses on the specificity of methamphetamine use, I have not reviewed these earlier pieces. Four of these articles are reports of Australian ethnographic research that took place in Sydney (Slavin, 2004a, 2004b), Melbourne (Dwyer, 2008) or Perth (Green & Moore, 2013). The fifth article is a case study of a person who uses methamphetamine in Melbourne (Duff, 2014). This small body of research rejects key assumptions of public health. These assumptions include that methamphetamine consumption is an inherently harmful practice and people who use methamphetamine are always at risk of harm and/or addiction. It offers alternative ways of understanding methamphetamine use. In doing so, it resists the way in which methamphetamine has been constructed through public health discourse and so contributes to a sociology *of* public health.

Sean Slavin's (2004a, 2004b) ethnographic research was situated in inner city Sydney, in an area of 24 hour street social activity. Participants in the research were gay men who often used methamphetamine, and who considered the recreational use of this drug and other 'party drugs' to be normal. Slavin (2004a) clarifies that his participants' general view is that recreational drug use is not 'morally wrong, but simply against the law' (p. 436). Heroin use and injecting drug use, however, are not normalised in this way. Instead they are considered beyond the boundaries of recreational drug use. In his work, Slavin (2004a, 2004b) draws out the distinctions between acceptable and non-acceptable drug use, showing how cultural practices, economic and social status, relationships, and spatial and temporal aspects act to shape and are themselves shaped by drug consumption. Slavin's articles foreground the role of pleasure and desire in drug use, two concepts that are mostly made absent in public health discourse (Moore, 2008). By making these aspects of drug use visible, Slavin's (2004a, 2004b) work challenges the narratives of harm, addiction and despair commonplace in literature underpinned by the values of public health. However, Slavin's work has other important theoretical aspects that I will discuss.

In his exploration of how gay men manage their methamphetamine use (some more successfully than others) Slavin (2004a) focuses on four men who are regular injectors of crystal methamphetamine. One of these participants is also an occasional heroin user. While these men share a geographical and cultural context, they move in different ‘scenes’ where crystal methamphetamine is used in different ways. By reporting on the different characteristics of crystal methamphetamine use among participants and their respective scenes, Slavin (2004a) focuses on particular effects of the drug and how some of his participants’ management strategies work and others fail in addressing these effects (p. 426).

Slavin employs the concept of ‘boundaries’ (Douglas, 1966, in Slavin, 2004a) to illuminate the ways participants incorporate methamphetamine use in their lives. For instance, participants exercise ‘control over themselves and the drugs they used’ (p. 455) by establishing ‘boundaries’ around their methamphetamine use and only using on the weekend or in certain places. Slavin uses this concept in a post-structuralist sense, where boundaries mark social and cultural spaces that are never ‘hermetic’ or ‘homogenous or static’ (Slavin, 2004a, p. 441). Thus, Slavin (2004a) argues that the most significant feature of drug use is its ‘liminality’, and observes that boundaries are never clear-cut (p. 457). To demonstrate the shifting and complex nature of boundaries, Slavin (2004a) provides an example of the exercise of control in his participants’ orchestration of ‘drug-use events’ (p. 442). Participants often made preparations for these events in advance, buying exactly the right amount of crystal, and stocking up with ample supplies of injecting equipment and other drugs such as amyl nitrate, cannabis and tranquilisers. Slavin suggests that with this extensive preparation his participants sought to exercise a high degree of control over their drug use. Yet, participating in these drug-use events also required being ‘out of it’ and losing inhibitions — a loss of control (Slavin, 2004a, p. 442). The idea of control, therefore, is not straightforward or clear-cut. Moreover, these drug-use events sometimes involved participants breaching boundaries in the pursuit of ‘excessive experience’ and this was ‘intrinsic to the experience and pleasure of the drug’ (Slavin, 2004a, p. 445). Thus, while boundaries were employed in a conventional sense by participants, such as in limiting the times and places where drugs were used, they were also shifting, and intrinsically part of the hedonism and pleasure involved in drug consumption.

In a second article, Slavin (2004b) gives an account of drugs, space and sociality in a gay nightclub. This article provides a vivid description of one participant’s (Tom’s) night out at a gay venue referred to as ‘the Eagle’, which involves methamphetamine consumption and a

sexual encounter. In examining a specific context in which drugs are consumed, various cultural and physical phenomena that produce drug use, including ‘sexuality, bodily dispositions and “tribal” affinity’ are explored (Slavin, 2004b, p. 268). To attend to the context in which Tom negotiates the use of drugs, (Slavin, 2004b) draws upon the work of Michel De Certeau (1988) and Gilles Deleuze and Felix Guattari (1998) to theorise ‘space’. De Certeau’s (1988) work provides a dynamic conception of spatial context. In it, ‘place’ is theorised as incorporating only the materiality of an environment, whereas space is created through elements such as social interaction, physical movements, mood and the ‘infinite possibilities of time’ (Slavin, 2004b, p. 289). Deleuze and Guattari’s work (1998) is employed to move beyond De Certeau’s approach (1988) in that, according to Slavin, it conceptualises space as a:

fluctuating, multidimensional, social and cultural field that occurs within but not bound by particular places. (Slavin, 2004b, p. 291)

Slavin (2004b) argues that when space is conceived in this way, rather than being reduced to context, it allows us to understand the ‘particularity and complexity of Tom and the culture in which he lives’ (p. 291). In turn, this provides insight into Tom’s methamphetamine use.

Using this theory allows Slavin (2004b) to conceptualise the space of the Eagle as constituted through multiple elements and phenomena. This includes a particular ‘tribe’ of gay men who delineate themselves through choices in clothing, drugs and music. Extremely loud and repetitive music, drug-taking and a mass of dancing bodies also materialise the space of the Eagle. Additionally, social interactions and exchanges constitute this space, including those involving the use of drugs and sex. Slavin (2004b) describes one of these exchanges, where Tom negotiates to take methamphetamine and have sex with someone he has just met:

In roughly a minute, through the blare of the music, and surrounded by a crowd, Tom and Nick negotiated to have sex at Nick’s house; to pick up two other men; to have sex without condoms based on the knowledge that they were all HIV positive; to take drugs to enhance the sex; and to inject those drugs. (p. 285)

Slavin also demonstrates the way in which the space is productive of drug use and drug users themselves. He finds that in Tom’s case:

spatialised sociality brings risk and pleasure into complex and dynamic relations. The drug spaces that may appear to exist only in the minds and bodies of those who have ingested them are not divorced from social or material contexts. All these elements

are part of a dynamic space — complex cultural fields in which drug users make themselves and are made by place (understood materially), bodies, and social practices. (Slavin, 2004b, p. 277)

However, while Slavin (2004b) finds that the spaces that Tom interacts with, and within, produce the possibility of methamphetamine use, he also argues that these spaces ensure that, for Tom, consuming this drug is ‘pleasurable, manageable and negotiable’ (p. 290).

Slavin’s (2004a, 2004b) theoretical frameworks enable him to provide a greater understanding of how gay cultural practices incorporate and produce methamphetamine consumption. He brings to light strategies that his participants employ to manage their drug use and identities, including that of boundary negotiation. He also shows that methamphetamine consumption is produced through space and sociality, rather than being merely the practice of an individual, illuminating how individuals embody themselves through social practices and spaces. Slavin’s goal is not necessarily to provide more data for the purposes of treatment or harm reduction interventions, yet his work is useful for both of these fields. In illustrating the ways in which individuals manage their drug use, Slavin’s work provides insights for treatment services seeking to help people to control their use. Showing how space contributes to the effects of drug use reveals how the employment of harm reduction strategies is dependent on myriad elements, rather than the agency of a single drug user. Moreover, by attending to drug use as always a temporal and spatially bounded phenomenon, Slavin contributes to a growing body of literature that rejects the concept of drug use as the pathological and/ deviant practice of individual drug users (Keane, 2011). I draw upon Slavin’s work in my thesis to produce an account of methamphetamine use that moves beyond drug consumption as an individual act. Like Slavin, I illuminate the many aspects that come together to produce drug use and drug users, including space and sociality, considering methamphetamine use as an ontological concern. Slavin’s work is also relevant in positioning my research, as he reveals the messiness of concepts such as controlled drug use. I continue this work, showing through participant accounts how drug use is not easily delineated as controlled and non-controlled.

While using bodies of theory different to Slavin’s, two other ethnographic accounts of methamphetamine (Dwyer & Moore, 2013; Green & Moore, 2013) also reject the conventional public health understandings of methamphetamine, seeking a more complex and nuanced exploration of this drug. Rachael Green and David Moore (2013) use normalisation

theory to illuminate how young people who use methamphetamine manage their identities in the face of public health discourse. Robyn Dwyer and Moore (2013) apply theoretical insights from STS to the issue of methamphetamine-related psychosis, showing how the lived experience of psychosis may differ from public health explanations. I now review each of these articles.

In an article concerning the way young people negotiate understandings of public health discourse and their methamphetamine use, Green and Moore (2013) present ethnographic research conducted with young people ('scenesters') engaged with the 'dance party' scene living in Perth, Australia. A theoretical framework of normalisation is employed in this article; specifically, the 'micro-politics of normalisation' (Pennay & Moore, 2010; Rødner, 2005; Rødner Sznitman, 2008). This approach concerns the way participants manage social responsibility and self-regulation in relation to drug use. Using this theory, the researchers explore the complex processes by which this particular network of drug users negotiated values associated with methamphetamine use, and the interplay between these values and those generated by dominant discourses such as public health.

Green and Moore (2013) posit that, at the time of the research, public discourses around methamphetamine use produced extremely negative understandings of the drug and the people who used it. Using methamphetamine was associated with stigma and harm, and young people who use this drug were thus required to manage their own perceptions of themselves in relation to these discourses. As Green and Moore (2013) observe:

The potency of the cultural representation of the problematic drug user — the addict or the junkie — among scenesters was undeniable. (p. 697)

In order to negotiate their own methamphetamine use and these strong, pejorative cultural representations of methamphetamine users, participants employed various strategies. These included using their social and economic status to differentiate themselves from 'problematic' methamphetamine users, not engaging with the language of addiction to describe their methamphetamine use (substituting words such as 'more-ish' for 'addictive' and defining their methamphetamine use as 'social'), and using discreetly when in social situations. Taking these strategies into account, the authors surmise that most participants responded to dominant representations of methamphetamine by aligning 'their identities with values of autonomy, control, and responsibility' (Green & Moore, 2013, p. 697). By doing so, their identity management strategies were defensive, actively countering what they did *not* want to be (Green & Moore, 2013).

Based on their findings, Green and Moore (2013) argue that cultural representations of methamphetamine use reinforce the false dichotomy of ‘recreational and problematic use’ (p. 698). This may cause young people to avoid seeking help for methamphetamine or other drug use, due to the highly stigmatised subjectivity of the problematic methamphetamine user. Green and Moore (2013) consider the needs of young people who engage in problematic methamphetamine use in terms of access to assistance, however, the focus of the article is the way in which dominant discourses such as public health contribute to very stigmatising understandings of drug users, even among drug users themselves. As the effects of this stigmatisation are brought to light in this research, Green and Moore (2013) contribute to a sociology *of* public health.

Dwyer and Moore’s (2013) article on methamphetamine use in Melbourne, Australia, critiques and re-imagines the link between psychosis and methamphetamine forged in biomedical literature (see, for example, McKetin et al., 2006b). These scholars use STS theory to assert that reality is multiple: produced and reproduced through practice, rather than an anterior, singular phenomenon. They then employ this insight to compare and contrast examples of contemporary public discourse on methamphetamine use with accounts from people who consume methamphetamine. Through this exercise they aim to:

re-emphasise the heterogeneity and variation in methamphetamine, to argue that it is not a stable, singular and definite object, and to point to the multiplicity and situatedness of methamphetamine effects. (Dwyer & Moore, 2013, p. 210)

Upon examination of the public discourse on methamphetamine, Dwyer and Moore (2013) find that this discourse:

enacts methamphetamine as an anterior, stable, singular and definite object that produces the inevitably distressing and pathological state of psychosis. (Dwyer & Moore, 2013, p. 209)

Yet, in accounts of methamphetamine use given by regular users ‘the drug and its effects are destabilised or rendered “messy”’ (Dwyer & Moore, 2013). For example, in one account of methamphetamine use, a participant says that upon taking methamphetamine straight for three days you:

just go insane, you lose your mind. You lose your marbles. You start hearing voices and freaking out and the whole world starts vibrating and just sort of want to curl up and sleep it off. (p. 207)

This certainly sounds like a frightening and unwanted effect of taking methamphetamine. However, the participant goes on to clarify that there is a somewhat enjoyable aspect to this experience. He says going insane is:

almost kind of enjoyable on a bad level as well. Like, you get that high, happy feeling and you enjoy that and then coming down, it's pretty shit but you kind of enjoy that as well. Like, when you take it next time, you know you're going to come down and go insane. But you almost look forward to that just as much as the high. (p. 207)

This participant's experience of the drug suggests that the relationship between methamphetamine use and psychosis is more complicated than allowed in public discourse (Dwyer & Moore, 2013). 'Freaking out' and losing your mind is, for some, a manageable, and somewhat enjoyable, part of taking the drug.

Using examples such as these, Dwyer and Moore (2013) find that presenting methamphetamine use as singularly harmful is not congruent with people's experiences of the drug. Moreover, they argue:

The examples we have provided from methamphetamine consumers highlight that in public discourse, the phenomenology of methamphetamine experiences is silenced in favour of pharmacology, psychology and neurobiology, and alternative accounts of these experiences — as potentially enjoyable, as produced by lack of sleep, as the result of additives — are excluded. (Dwyer & Moore, 2013, p. 208)

This statement makes visible the political nature of discourse, as dominant discourses suppress accounts of reality that are not congruent with their assumptions. Dwyer and Moore (2013) go on to argue that a consequence of this singular construction of methamphetamine is that it undermines harm reduction. If methamphetamine is reified as a singularly harmful substance, harm reduction becomes an inappropriate response. It is not possible to develop strategies to reduce harm for such a destructive and addictive drug. Dwyer and Moore (2013) recommend a return to the original principles of harm reduction, in which harm is sought to be reduced, rather than drug use itself. Although the authors present their findings in relation to harm reduction, a practice that emerges from public health discourse (Keane, 2003), this is done in a way that both critiques current harm reduction practice and seeks to incorporate alternative understandings of drug use (in this case user experiences). By doing so, this research contributes to a sociology *of* public health.



Both Green and Moore (2013) and Dwyer and Moore (2013) are significant in positioning my research. These articles posit that methamphetamine consumption and the ways which users understand themselves are shaped by broader, authoritative discourses, such as public health. This illuminates the ontological politics of methamphetamine-using subjects, showing that identity is a contested and open domain. This is a main aim of my research: to show that the limited ways in which we currently understand methamphetamine users are not ‘natural’, but instead are shaped by hegemonic understandings. Further, Dyer and Moore (2013) show the messiness of methamphetamine consumption experiences. My work continues this scholarship as I examine the ways in which methamphetamine users and harm reduction/treatment practitioners embrace dominant understandings of drugs, but also reject and subvert these, rendering them messy and multiple.

Cameron Duff (2014) has authored an article concerning the way drug use practice produces context that is particularly relevant to positioning my work. Duff (2014) presents this research with the aim of transcending more traditional structural understandings of context. His goal is to:

clarify the active, local and contingent role of contexts in the mediation of what bodies do ‘on’ and ‘with’ drugs. (Duff, 2014, p. 634)

Duff (2014) uses a case study of Bill, a methamphetamine user, to make his argument. Duff explores Bill’s drug consumption using ‘assemblages’ as units of study. That is, the connections and relationships Bill has with the various objects and subjects, spaces and environments with which he interacts. Duff (2014) argues that attending to the connections within assemblages — using assemblage thinking — provides us with a novel view of drug use (p. 633).

The article describes a difficult period in Bill’s life related to his employment and housing. Bill works casually<sup>3</sup> on night shift in a petrol station, often using methamphetamine during his shift. He lives in a rented bungalow. His circumstances take a turn for the worse when he is sacked from his job and evicted from his bungalow. Rather than becoming homeless, Bill is able to rely on social contacts and the Salvation Army to help out. The Salvation Army provides him with transitional housing. In telling Bill’s story, Duff eschews structural explanations of drug use, such as poverty. He argues:

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<sup>3</sup> ‘Casual’ work refers to employment on a shift-by-shift basis, with no obligation on the part of the employer to provide set hours or on-going employment.

Rather than regard Bill's predicament as a function of his powerlessness in the face of structural factors (such as the casualisation of unskilled labour in Melbourne; or disinvestment in public housing), 'assemblage thinking' highlights the ways Bill was able to mobilise novel relations and resources in response to the shock of losing his home and his work in quick succession. (Duff, 2014, p. 635)

By making visible the connections and relationships in the assemblages within which Bill is enmeshed, he is embodied as resourceful and responsive to problems in his life. Conventional accounts would focus on his disadvantage as explained through the structural factors mentioned by Duff in the above quote. These would then obscure Bill's resourcefulness and ability to mobilise his resources.

At the same time, assemblage thinking does not necessarily discount the effects of economic and social marginalisation. While rejecting structural explanations for Bill's predicament, Duff goes on to argue that assemblage thinking is able to make visible the effects of broader structural factors such as poverty at a local level:

Too much social science analysis of AOD use discovers in the midst of consumption the trace of social and structural forces, without describing how these forces actually participate in AOD use in particular places, at particular times. (Duff, 2014, p. 637)

In Bill's account of methamphetamine use, poverty is made visible through its effects. For instance, Bill is made homeless and is required to go to a charity organisation for housing assistance. At the same time, in this account, Bill is not rendered powerless by poverty. Rather, assemblage thinking shows us how his choices are shaped by wider forces through tracing their effects.

This is an important point, particularly for drug research. Much of the body of scientific research on methamphetamine use is built upon participants who have experienced years of heavy drug use, unemployment and limited education. The conclusions drawn by this research typically make absent the glaring social and economic disadvantage of participants. Rather, methamphetamine is generalised as a drug that causes violence (McKetin et al., 2014), depression (McKetin, Lubman, Lee, Ross, & Slade, 2011) and psychosis (McKetin et al., 2006b) with little or no recognition that the participants in this research have unusually limited connections to the labour market, education and economic security. This is not to say that these limited connections are the alternative cause of violence and psychosis; however, their effects should be revealed and described so that the complexities of violence, psychosis

and addiction are apparent, and these phenomena are not attributed solely to use of the drug methamphetamine.

Duff (2014) argues that assemblage thinking offers workable strategies to inform the various practices around drug use:

The best research, the best policy advice, and the best harm reduction praxis never ceases to concern itself with the real conditions of consumption; with the specific circumstances in which bodies, spaces and substances interact in the event of AOD use. (Duff, 2014, p. 638)

Here Duff notes the pragmatism of assemblage thinking. Local descriptions of drug assemblages can be strategic in terms of bringing about positive change for people who use drugs. In my research I make visible economic and social deprivation in assemblages by showing the effects of reduced connections and relationships with significant resources. I do so to show how assemblages enable drug users in various ways, and that peoples' ability to manage and/or control their drug use is produced within these assemblages. In doing so, I employ assemblage thinking, building upon Duff's work in this area.

The five articles reviewed above contribute to a sociology *of* public health. They resist interpreting methamphetamine use solely in terms of unexamined categories of addiction and harm; rather, they critique these concepts. Methamphetamine use is not seen as having a singular trajectory of addiction and recovery; instead there are multiple experiences of use, with people managing methamphetamine consumption in various ways. Subversive concepts related to drug use, such as pleasure, are exposed. Participants in this research are multidimensional subjects who engage in methamphetamine use, sometimes pleasurable, sometimes harmful, but always the product of a multiplicity of elements, rather than solely their own agency. These accounts of methamphetamine use counter and resist public health discourse yet can, and should, be considered by public health practitioners seeking more nuanced, effective and less stigmatised ways to understand and address methamphetamine use.

### **Textual analyses of methamphetamine-related media and policy**

Within the body of literature that I classify as a sociology of public health, there is a corpus that concerns textual analyses of methamphetamine-related media and policy. This literature is relevant to my research as it addresses the way in which methamphetamine is constructed or understood through media and policy texts. This is because my research explores the

representation of methamphetamine in scientific, policy, treatment and media texts. This corpus, originating from North America and the UK, features drug ‘panics’ (Ayres & Jewkes, 2012; Jenkins, 1994), ‘scares’ (Boyd & Carter, 2010) or ‘moral panics’ (Armstrong, 2007; Linnemann, 2010). I do not review the entire body of methamphetamine ‘panic’ literature; rather, I have selected two key articles (Armstrong, 2007; Jenkins, 1994). Jenkins (1994) is a seminal article outlining the construction of the first methamphetamine panic in the US, while Armstrong (2007) is a good example of how panics act to marginalise groups along existing social divides, such as poverty. Both articles also provide examples of the contradiction inherent in panic accounts, which I will discuss in this section. As I will explain, these accounts use a social constructionist viewpoint to investigate the methamphetamine problem as a product of social, political and economic forces.

Social constructionism is a school of theory that argues that the world we experience is a product of social processes. Panic theory uses elements of social constructionism in that it sees drug panics as socially constructed rather than objectively real. An ‘ice panic’ — or ‘drug panic’ and moral panic more generally — is a phenomenon involving ‘disparity between the perceived threat of a substance and the actual harm involved’ (Jenkins, 1994, p. 7). Thus, panic theory is based upon drawing attention to the gap between the socially constructed elements of the drug panic versus the actual problem. It assumes an anterior reality and that some accounts are closer to this reality than others. This leads to an underlying contradiction in the theory, as some realities are ‘real’ and others are socially constructed. Nonetheless, this body of work is important to my research as it demonstrates the way in which methamphetamine discourse shapes and reinforces very conventional ideas around poverty and gender, and further scapegoats and stigmatises those people who use the drug. These are all ideas that I take up in my research. However, rather than address what is real and what is not, I argue that *all* knowledge and realities are constituted through practice.

In this section I also review an article by Fraser and Moore (2011). These authors use post-structuralist methods of policy analysis to examine policy documents addressing amphetamine-type stimulants (ATS). Fraser and Moore (2011) move beyond panic accounts as they employ theory that argues reality is not an anterior and stable phenomenon; rather, all forms of knowledge (and reality) are constructed. Thus, these authors are not concerned with arguing about the dimension of the methamphetamine ‘problem’, but rather with illuminating the ways in which methamphetamine use is constituted as a problem and the effects of this. While using different schools of theory to critique the methamphetamine problem, both panic

accounts and Fraser and Moore (2011) contribute to a sociology *of* public health. This is because the problem of methamphetamine use is not seen as the sum result of individuals experiencing harm as is the case in public health. Instead it is considered a socially constructed phenomenon, or, as Fraser and Moore (2001) argue, produced through policy, with specific political effects.

Phillip Jenkins' (1994) work describes and deconstructs the ice panic that occurred in the US in the 1990s. Jenkins argues that the way in which the US media reported methamphetamine use (specifically ice use), and related government activities in the early 1990s constituted an 'ice panic' (p. 7). Jenkins (1994) considers the ice panic itself to have been short-lived, peaking around 1989 and 1990 in a series of US Congressional hearings. The article is based on the idea that scrutinising the ice panic can reveal the way in which crime and deviance are socially constructed, and the role that government activity plays in this. As Jenkins explains:

The panic itself is valuable in itself for what it suggests about the perceptions of a society as a whole, and specifically of policy makers and legislators. The incident thus has great significance for understanding the social construction of crime and deviance. (p. 8)

Building on this assumption, Jenkins then outlines certain political and media events in the US that, he argues, constructed this particular panic. A key point in Jenkins' (1994) argument is that ice use was only ever a problem in Hawaii. He finds that this problem was then extrapolated to a national epidemic as a result of political rivalries within that state (p. 8). He argues that, in addition to the events in Hawaii, the ice panic was driven by other factors including:

the existence of specialised agencies and investigative bodies focusing on drug issues, and the intensification of public expectations and fears following the crack scare. (Jenkins, 1994, p. 8)

Jenkins' (1994) analysis is important as it shows the way social and political aspects shape expectations of a drug's effects, rather than seeing drugs as having inevitable effects based on their apparently stable materiality. Jenkins does, however, refer to the 'real' problem of ice, positing that ice use *was* a significant problem in Hawaii. This point flags an underlying contradiction in panic accounts: that some 'truth' is constructed and some is not. Nonetheless, Jenkins' account is valuable, showing the ways in which political and media activity produced an ice panic. Jenkins concludes that the elements that led to the 1990s 'ice panic'

are still in place in the US and predicts that it is highly probable that a drug ‘panic’ will re-occur.

A series of articles (Armstrong, 2007; Boyd & Carter, 2010; Linnemann, 2010; Linnemann & Wall, 2013) published in the decade following Jenkins’ (1994) publication confirm his assertion that ‘[t]he ice incident is likely to be repeated in various forms’ (p. 9). The focus of this literature is the extensive reportage of methamphetamine use, demonstrating that methamphetamine use again became a significant public concern in North America. These articles uniformly concern themselves with the representation of people who use methamphetamine in the news and popular media. They show how these representations reflect and reinforce dominant discourses, contributing to existing social, economic and gender divisions.

An article by Edward Armstrong (2007) finds that methamphetamine is of particular concern to law enforcement agents in rural America. He applies a moral panic (Goode & Ben-Yeduda, 1994) conceptual framework in order to understand how the problem of methamphetamine is socially constructed (p. 429). Armstrong uses Goode and Ben-Yeduda’s (1994) outline of the characteristics of a moral panic to examine the methamphetamine panic, describing the five features that signify a moral panic in this way:

First, there is a heightened level of concern over certain behavior. Next, there is hostility linked to the category of people responsible for the threatening behavior. The targeted individuals are seen as evil. Third, there is public consensus that the threat is real. Fourth, there is disproportionality — the perceived threat is far removed from any objective measure of seriousness. Finally, there is volatility. Moral panics erupt suddenly and subside just as quickly. The meth scare encompasses all of these dimensions. (p. 429)

Armstrong then goes through each of these features to argue that the portrayal of methamphetamine use constitutes a moral panic in the US. He uses examples of political events, such as the passing of the Combat Meth Act in the US Senate on January 23, 2005 (Armstrong, 2007, p. 429) as well as media reports, to argue his case.

This article is a useful deconstruction of the US methamphetamine moral panic, however, in asserting what is true about methamphetamine, Armstrong (2007) draws attention to problematic elements of panic arguments — as noted above in my discussion of Jenkins (1994). This occurs when Armstrong (2007) attempts to disprove some of the assumptions

about methamphetamine in order to assert what is ‘really’ happening, and show that moral panic around methamphetamine is undeserved. For instance, he states that ‘[m]edical researchers appear unified in their opinion that amphetamines do not cause “physical dependence”’ (Armstrong, 2007, p. 437). He also argues that ‘[r]ecent research appears to cast additional doubts on meth’s addictive properties’ (Armstrong, 2007, p. 437). Here, Armstrong attempts to assert methamphetamine is *not* an addictive drug using scientific evidence. By arguing for the existence of particular properties of methamphetamine, Armstrong understands methamphetamine as a pre-existing anterior substance. Moreover, there are ‘real’ accounts of this substance — scientific ‘fact’. Armstrong’s (2007) argument here is indicative of the tensions in panic accounts. He is attempting to argue what is really happening while at the same time positing that the problem of methamphetamine is a constructed one (Fraser & Moore, 2011).

More successful is Armstrong’s (2007) documentation of the ways in which the methamphetamine panic has exacerbated existing social divisions in the US. This is done by documenting examples of the hostility faced by people who are supposed users of methamphetamine — the white, rural poor. Armstrong (2007) argues that methamphetamine is portrayed as a ‘white trash’ drug (p. 432) and that constructing methamphetamine in this way scapegoats the rural poor. As a result he believes that ‘the meth scare is blinding people to the plight of white, underclass, rural, poor people’ (Armstrong, 2007, p. 438). Thus, a political effect of the moral panic concerning methamphetamine use in the US is that the rural poor are viewed as criminal. These people are considered consumers and producers of methamphetamine, meaning that they are deserving of their poverty, relieving the community or state of responsibility for any hardship they may face.

The two panic articles I have reviewed offer insights into how news media and government activity are powerful sources for what we know about methamphetamine and people who use it. I have argued that panic accounts are contradictory; there is a distinction made between a constructed problem of methamphetamine use (the panic) and the real problem of methamphetamine use (what is actually happening). Nonetheless, these articles make important contributions to sociological methamphetamine literature. They are particularly successful in demonstrating the political effects of panics, arguing that they further marginalise and scapegoat certain populations. By doing so, they show how the knowledge around methamphetamine draws upon hegemonic assumptions about gender, race, poverty and criminality, effectively producing and re-producing these understandings.

Fraser and Moore (2011) also address the way methamphetamine is produced in textual accounts, but do so by using a post-structuralist theoretical framework. These authors address the way that ATS (including methamphetamine) are produced as problematic through Australian policy documents. They note that social constructionist accounts of panics are useful in showing both the social and political nature of drug panics as well as how these act to marginalise particular groups of people. However, Fraser and Moore (2011) depart from this work by explaining that they:

make no claims regarding the ‘true’ relationship between the extent of a ‘problem’ and the official response to it. (p. 500)

These authors thus avoid the limitation of the earlier work that I have outlined above. Fraser and Moore (2011) also find that the analytical tools employed in panic accounts of methamphetamine use are not sufficiently subtle to capture the way in which the drug problem is materialised in Australian policy texts. These texts are more complex in what they produce, whereas the notion of panic suggests highly sensationalised and overblown coverage of methamphetamine use and downplays the role of other ambiguity in the discourse.

According to Fraser and Moore (2011), following Bacchi (2009), drug policy creates rather than responds to drug ‘problems’. Using post-structuralist analyses, they demonstrate how ATS are produced as a certain kind of problem which, in turn, allows for certain kinds of policy development (Fraser & Moore, 2011, p. 500). The authors analyse ATS policy in Australia by attending to harms and causation as ontological concerns and evidence as an epistemological concern. This is because they argue that the relationship between ontology and epistemology — between the nature of reality and knowledge about reality — is reciprocal. Studying the world does not simply describe it; instead, it shapes it (Fraser & Moore, 2011, p. 501). They first examine an ontological concern: drug harms and causation — what do drugs do to bodies and societies? They follow this with examination of an epistemological concern: evidence — what do we know about ATS? In doing so, the authors ‘identify important slippages between what is treated as known and what is assumed’ (Fraser & Moore, 2011, p. 501). Without these ‘slippages’ they argue that ‘much of what is said in the documents about ATS use as a problem would become difficult or impossible to sustain’ (p. 501). Thus, Fraser and Moore (2011) demonstrate that the methamphetamine problem is not the sum of the harms experienced by those individuals who use the drug, nor is it a socially constructed panic. Rather, it is carefully produced through policy texts, but with



evidence that is, at best, thin and incomplete and handled in confusing and contradictory ways.

While the textual analyses reviewed above employ different theoretical frameworks, the accounts of panics from North America and the UK, and Fraser and Moore's ATS policy analysis, all contribute to a sociology *of* public health. This small body of literature addresses the methamphetamine problem as a constructed one, recognisable by the way in which it produces and reifies dominant ideas about drug users, race and gender. My work will contribute and extend upon these analyses. That is, I assume that all knowledge is contingent, rejecting the idea that there is a true (and benign) account of reality. I use theoretical tools similar to those employed by Fraser and Moore (2011) to address knowledge concerning methamphetamine as constructed, including the scientific literature. In this way I avoid the inconsistency of panic accounts, and move beyond positivist assessments of what is the real methamphetamine problem.

### **Party drugs and the theory of normalisation**

A separate body of work that concerns methamphetamine is 'club drug' or 'party drug' literature. This literature details the use of drugs such as ecstasy, gamma-Hydroxybutyric acid (GHB), ketamine<sup>4</sup> and sometimes methamphetamine (see, for example, Duff, 2005; Pennay & Moore, 2010). These texts are noteworthy, but are not of great significance in positioning my work. Although they concern drugs, 'clubbing' or 'dance party' culture is also a major concern and methamphetamine is not the central drug. Further, they employ a different theory — that of normalisation — than the theory that underlies my work. Nonetheless, this body of work explores the way in which culture produces particular understandings of drugs and drug use practices. I briefly review a key Australian paper (Pennay, 2012) from this body of work that provides insight to the way young people in Melbourne use methamphetamine, as it is useful in positioning my work.

Normalisation is theory that emerged to explain the shifting attitudes and cultural norms around drug use in Europe and particularly the UK (see, for example, Measham, Newcombe, & Parker, 1994; Parker, Aldridge, & Measham, 1999; Parker, Williams, & Aldridge, 2002). It was argued that young people no longer consider drug use a deviant activity and that this

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<sup>4</sup> These drugs are all taken illegally and often associated with the dance or party scene in Australia (Duff, 2005). Ecstasy is a colloquial term for 3,4-methylenedioxy-N-methylamphetamine (MDMA). GHB is a colloquial term for gamma-Hydroxybutyric acid.

changing status has implications for the way in which policymakers and public health deal with the drug (Duff, 2005).

Amy Pennay (2012) uses normalisation as a way to frame young people's methamphetamine use and other party drug use. In her ethnographic account, Pennay describes how a group of 'mainstream' youth engages in illicit drug use, albeit with particular boundaries around this use. Methamphetamine is used by this group to enable them to 'control' themselves, or straighten up, when in public spaces such as mainstream dance or club venues. Thus, methamphetamine is used as a drug to appear normal — rather than drug-affected. One of Pennay's participants explains her use of methamphetamine as follows:

If we're too pissed [on alcohol] we'd usually have it [methamphetamine] to straighten us out. I never go anywhere without my little vial, just in case. If someone gets too fucked on ecstasy or too pissed or something I always carry it around, like an emergency, to straighten them out. (Interview: December, 2006) (Pennay, 2012, pp. 413–414).

This quote shows how the drug is strategically employed in order to appear straight and stay up to engage in long periods of partying. This offers an alternative narrative to that presented by public health. Pennay's participants are not out of control on methamphetamine; they use it to remain *in* control. Thus, while Pennay's work has an alternative theoretical underpinning to my own, it has similarities in that it presents accounts of methamphetamine use that challenge dominant discourses.

There are insights to be gained from the literature that concerns club and party drug use, typically framed by the theory of normalisation. Most notably, this literature shows how drug use practices shift in relation to changing cultural norms, and that drug use itself has many outcomes. However, the focus on dance culture, and party drugs, rather than methamphetamine specifically, as well as the use of theory with which I have not engaged, means that this work, as a whole, is not key to positioning my research. Nonetheless, it is a body of work that contributes to alternative and more nuanced understandings of drug use and contributes to a sociology *of* public health.

### **Critical accounts of drug use**

There is an extensive body of sociological work on drugs (see, for example, Dwyer & Moore, 2010a; Fox, 2002a; Fraser, 2004; Gomart, 2002; valentine & Fraser, 2008; Vrecko, 2009; Weinberg, 2000). I have not reviewed this body as a whole, choosing instead to focus on the

considerable volume of work in which methamphetamine use is central. Instead I have selected three sociological articles on drug use that draw on theoretical concepts that I use in my thesis and are relevant to positioning my work. I begin with two articles by Kate Seear and Suzanne Fraser (2010a, 2010b) that interrogate the concept of addiction through highlighting the voluntariness/compulsivity binary that underpins this term. These authors are concerned with the concept of agency and how it is subverted in particular accounts of drug use. My work also addresses this concept and how it is constituted through the myriad elements that come together in drug use. I then review an article by Kylie Valentine (2007) that concerns methadone treatment, looking at the ways in which treatment practice and broader cultural narratives make up multiple methadone-related identities. Valentine's work is significant in positioning mine, as I also describe ways in which drug users constitute themselves through local networks but draw upon hegemonic ideals to understand their drug use.

Seear and Fraser (2010a, 2010b) explore agency and addiction in two articles about Ben Cousins, a former and very successful Australian Football League (AFL) player. At the height of his career, Cousins was found to be using methamphetamine, resulting in, amongst other things, his suspension from the game for 12 months. Seear and Fraser (2010a, 2010b) chart Cousins' subsequent fall from grace and his vilification in the media, as well as by the AFL. They interviewed Cousins about his methamphetamine use and the way he understood his subjectivity as an athlete and a drug user/addict. In their article, they examine how rarely combined attributes — that of addiction, and sporting virtuosity and leadership — were represented by the media as well as understood by Cousins himself (Seear & Fraser, 2010a, 2010b). While their work focuses on Cousins' methamphetamine use, the focus is not on methamphetamine *per se*, but rather concepts such as addiction and masculinity and related binaries such as voluntariness/compulsivity.

To address agency and addiction, Seear and Fraser (2010b) first outline the political effects of the now generally accepted 'disease model' of addiction. They argue that this model provides a scientific explanation for what has previously been understood as a 'failure of the will' (p. 180). Seear and Fraser (2010b) then claim that although some scholars argue this model has alleviated the stigmatisation of drug users, the disease model:

has merely shifted the forms of stigmatisation in action...the failure of the will conventionally associated with addiction is actually institutionalised as an illness,

crystallising, rather than disrupting, essentially arbitrary negative judgements about drug users. (2010b, p. 180)

These authors argue that while the disease model means that people who are addicts can identify as sick, they are sick in such a way that ‘impacts on the sufferer’s social and political standing as a legitimate subject or citizen’ (Seear & Fraser, 2010b, p. 180). In this way, conceiving of addiction as a disease is still stigmatising for those who use drugs.

Seear and Fraser argue that the issue of illicit drug use in elite sport brings to light the problem of agency and drug use. Elite athletes are exemplars of masculinity, with a ‘high capacity for self-discipline, and mental and physical strength’ (Seear & Fraser, 2010b, p. 180). Seear and Fraser note that despite his methamphetamine use off-field, Ben Cousins’ quality of play was unaffected. This leads them to argue that Ben Cousins’ ‘fit/addicted’, ‘disciplined/intoxicated’ body challenges assumptions about both sports players and drug users, as the intersection of addiction and athleticism disrupts the addicted body (as typically constituted as passive, unhealthy and compulsive) (Seear & Fraser, 2010b).

By describing key events following the revelation that Cousins was using methamphetamine, the authors show how the expectations around Cousins’ behaviour reflected subjectivities seemingly at odds with each other. On the one hand, Cousins was a highly regarded sportsman, on the other, a drug addict. In this way he was simultaneously:

in control and out of control, manipulative and subject to the demands of his addiction, criminal and victim, culpable and innocent, ‘sick’ and evil. (Seear & Fraser, 2010b, p. 185)

Central to these multiple subject positions is the concept of agency, and Seear and Fraser (2010b) argue that in returning to football Cousins was required to be demonstrably sorry. This involved enacting:

a particular, highly complex version of subjecthood in which he [Cousins] must both claim and disavow agency so as to successfully navigate the mixed expectations imposed on him by popular but insufficiently nuanced concepts of addiction. (Seear & Fraser, 2010b, p. 186)

Thus, as the ‘sorry addict’, Cousins embodies a ‘paradox of agency’. He is, at the same time, obviously athletic, and an addict — and thus compulsive. These authors suggest that Cousins’ embodiment of these traits require us to question our understandings of agency and drug use, moving beyond the dysfunctional and passive subjectivity of the ‘addict’.

In the second article, the authors explore Cousins' understanding of addiction and his drug use (Seear & Fraser, 2010a). Interviewing Cousins, the authors find that he understands drug use and sporting prowess as 'mutually interdependent' and as 'balancing each other out' (p. 446). Thus, while understanding himself as an addict, Cousins also considers compulsion as an important part of his sporting success. At one point he states:

the very things that make me a good footballer are the very same traits that make me susceptible to being a drug addict. (Seear & Fraser, 2010a, p. 448)

The authors argue that this shows Cousins understands himself as 'both compulsive and voluntaristic with each reliant on each other for its existence' (p. 448). Further, they find that for Cousins, inauthenticity resides not in his 'addiction' but in being unable to be truthful about his drug use because of the 'unreflective and normalising conventional approach to it' (Seear & Fraser, 2010a, p. 449). Thus, they suggest:

The problem for Cousins is that his desire to be liberated from the 'lie' of voluntarism and compulsivity as polar opposites — and his aspiration to tell the truth about himself — is not possible for so long as the normative fantasy of compulsivity and voluntarism as mutually exclusive exists. (Seear & Fraser, 2010a, p. 449)

Seear and Fraser draw upon Eve Sedgwick's (1992) work to offer an alternative to absolutes such as the voluntarism/compulsivity dichotomy that frame our current understandings of drug use. Sedgwick (1992) suggests the concept of 'habit' is one that captures the 'regularity and complexity' of a practice such as drug use (Seear & Fraser, 2010a, p. 450). Seear and Fraser argue that this move captures the idea of practice as a constitutive of ourselves, where habit is about 'worldly practices that constitute selves, others and the surrounds' (p. 449). Habit is not good or bad, it is constitutive of all of us — 'addicts' and others.

In their work, Seear and Fraser argue that Cousins' experience of 'addiction' disrupts our conventional understandings of this concept. In doing so, it raises questions about the policy and treatment responses underpinned by these understandings. On a broader level, it challenges disease models of addiction that produce people who use drugs as 'less-than-full citizens' (Seear & Fraser, 2010a, p. 450). They argue that, rather than being shaped by dualism such as disease models of addiction, policy and treatment responses must be:

shaped by and resonate with the diverse range of individual experiences with and accounts of drug use, especially those that challenge assumptions about the 'compulsive' subject. (Seear & Fraser, 2010a, p. 452)

This would entail meeting those who take drugs ‘in the domain of their own experience’ (Seear & Fraser, 2010b, p. 189).

Seear and Fraser’s (2010a, 2010b) work is relevant in positioning my own as they explore the concept of agency and drug use. Using the example of Ben Cousins, these authors bring to light the very limited ways we have of understanding drug use. In my work I also explore the enactment of the voluntariness/compulsive binary (and other drug using ‘absolutes’) and how people embrace or resist this understanding of addiction and drug use. Moreover, I further the work of Seear and Fraser by showing the specificity of the binaries that underpin methamphetamine consumption and how people who use methamphetamine draw upon these to understand themselves.

Finally, I review valentine’s (2007) article concerning methadone treatment. Valentine’s (2007) research involves in-depth interviews with 35 people on methadone maintenance in Sydney, Australia. This work is important in terms of positioning my own, as it argues that localised treatment practices are constitutive of certain types of drug users. At the same time, valentine argues that people also understand themselves in terms of broader social forces. She thus draws on theorists such as Ian Hacking and Nikolas Rose to understand the ‘making up’ of consumers of methadone maintenance treatment from ‘above’ (through hegemonic understandings of drug use) and ‘below’ (through localised treatment practice) (valentine, 2007, p. 511). Valentine demonstrates how methadone maintenance is performative by looking at the way treatment networks — phenomena such as methadone, treatment practices such as prescribing and picking up a dose from the pharmacy, and subjects such as prescribers and consumers — constitute particular subjectivities.

In addition to describing the productive nature of localised networks of treatment, valentine also draws upon Hacking (2002) and Rose (2007) to understand ‘the processes by which social identities form and change’ (valentine, 2007, p. 511). She suggests that in order to capture the relationships of power, work and sociality embedded in the ‘real’ world, work that explicitly investigates the nature of the ‘social’ is required. To do this, valentine employs Hacking’s concept of historical ontology, in which particular subjectivities are made available to individuals. She argues that ‘drug addict’ is one such category:

Drug addiction, a historically specific, and historically locatable condition, that is an established part of medical taxonomies and a recognisable cultural stereotype, could surely be any part of any project of historical ontology. (valentine, 2007, pp. 499-500)

Valentine also uses the work of Rose (2007) and his concept of 'biological citizenship' to illuminate how:

changes in the means by which medical, legal and other authorities understand people and those in which people have come to understand and produce narratives of themselves. (valentine, 2007, p. 498)

Valentine thus uses Hacking and Rose to show that broad social forces create particular spaces within which people can 'make themselves up'.

Guided by these theoretical insights, valentine outlines identities 'made up' by methadone treatment. One identity she brings to light is that of the 'lay carer' (valentine, 2007, p. 508). This identity is one produced through the practice of caring for others that are 'hanging out' (withdrawing from heroin or other opioids), and involves the diversion of prescribed methadone. As one participant explains:

And we've had friends that have been...sick and um we've given them some [methadone] to get through...I mean hanging out sick. (valentine, 2007, p. 509)

Valentine (2007) argues that this identity is one that suggests 'negotiations of medical regulation and care that are largely unrecognised' (p. 509). Here consumers divert their methadone (a practice regarded as non-compliant and indicative of addict behaviour) for the purpose of caring for friends or acquaintances. It undermines critiques of drug treatment as 'paternalistic and debilitating' and also troubles 'easy' distinctions between compliant and disobedient (valentine, 2007, p. 510). The localised practices of methadone treatment — the informal networks of sharing and exchange — enable the constitution of the lay carer. But it is also the negotiations of broader fields of medical knowledge and policy around methadone provision that enacts this social identity. Thus the making up of the lay carer occurs from both 'above' and 'below'.

Valentine's consideration of local practices and the work of Rose and Hacking is important in positioning my work. My research examines how authoritative discourses — those that produce broad understandings of the world — make available understandings of methamphetamine and methamphetamine-using subjects. In doing so, like valentine, I draw upon broader critiques of the social, using Foucault and Rose to understand the ways in which subjects constitute themselves as highly agentic, as without power, or in other ways. And, similar to valentine, I seek to understand the ways in which localised assemblages of human and non-humans produce particular types of drug use and treatment, and how specific

practices are also productive of subjectivity. In this way my work builds upon valentine's insight that there is value in pulling together empirically-driven research, while remaining cognisant of the broader social forces that shape individuals understandings of themselves. Further, in applying these insights to the area of methamphetamine consumption and harm reduction/treatment practices, my work produces new insights about this particular drug.

Seear and Fraser (2010a, 2010b) address the problem of agency and drug use, and this is a central theme in my work. In my thesis I show the way in which understandings of agency vary according to the broader networks in which people are enmeshed. Valentine (2007) shows how people constitute themselves through local practices, drawing on broader discourses. I continue this work, demonstrating the political nature of ontology. By showing how people who use methamphetamine embody themselves both through practice and in relation to broader discourses, I reveal the ways in which these forces shape methamphetamine consumption, but how people might resist or subvert these. This brings to light the contested nature of realities and opens up other possibilities for knowing drug use.

## **Conclusion**

In reviewing the qualitative sociological literature on methamphetamine, I have argued that as a body of work it acts as either a sociology *for* public health or a sociology *of* public health (Moore, 2004). The majority of qualitative research concerning methamphetamine falls into the former category. This literature works to reveal an increasing range of pathologised subjects as well as aiming for a deeper understanding of these subjects and/or their 'addiction' and 'abuse'. By situating research findings solely in relation to addressing methamphetamine 'abuse' and 'addiction', this literature intensifies the scrutiny of people who use drugs, as it understands them as always in need of intervention. This then further scapegoats those who use drugs, seeing these individuals as the sole cause and site of drug-related harm. Further, as this body of work interprets data through a public health lens, other aspects of participants' practice that might challenge current ideas about methamphetamine are not foregrounded, and findings are presented in terms of an addiction/recovery binary. This means that this corpus reproduces hegemonic assumptions about people who use drugs, and contributes to their pathologisation and marginalisation.

There is, however, a small and significant body of work that includes critical qualitative accounts of methamphetamine use from Australia (Duff, 2014; Dwyer, 2008; Green & Moore, 2013; Slavin, 2004a, 2004b), social constructionist accounts of the methamphetamine



panic in North America (Armstrong, 2007; Boyd & Carter, 2010; Jenkins, 1994; Linnemann, 2010) and the UK (Ayres & Jewkes, 2012), and Fraser and Moore's (2011) post-structuralist analysis of ATS policy in Australia. It also includes accounts of drug use more broadly such as Seear and Fraser (2010a, 2010b) and valentine (2007) and party drug research (Pennay, 2012). I have argued that this work contributes to a sociology *of* public health. These accounts of methamphetamine challenge the idea that consumption of this drug is solely addictive and harmful and foreground concepts such as pleasure. They also challenge the link between public health concepts such as psychosis and methamphetamine use, arguing that methamphetamine effects are both 'messy' and multiple, rather than singularly harmful. Analyses of media and policy show the way in which methamphetamine use is understood, or 'made', through dominant discourses. This work illuminates the conditions of possibility that are productive of the ways in which we can understand, practise and know drugs.

My research adds to, and extends upon, this body of critical work. It mobilises theoretical concepts rarely used in the area of methamphetamine use and related service provision, applying them to authoritative discourses such as science, policy and treatment, as well as methamphetamine-related practices. In addressing authoritative texts in relation to methamphetamine, I make a novel contribution by examining the way science 'makes' methamphetamine, disrupting accepted truths about the materiality of this drug. I also build upon the work of Sedgwick (1992) and others (Fraser & Moore, 2008; Keane, 2004; Seear and Fraser, 2010a, 2010b) who have elucidated the absolutes of drug use. I extend this work, showing how methamphetamine users are enacted in extreme absolutes, and illuminating how this specificity is possible. Through extensive interviews with users and service providers I collate accounts of practice, describing the assemblages of consumption and service provision. By treating assemblages as ontologically significant, I build upon the work of scholars such as Duff (2014), illuminating multiple ways in which drug users and drugs are constituted through material—semiotic networks. Further, by showing the ways in which authoritative accounts of methamphetamine use shape practice, I contribute to the work of a range of scholars (Dwyer & Moore, 2013; Green & Moore, 2013; valentine, 2007) in this area. My research is unique, however, as I identify specific enactments of methamphetamine and methamphetamine-using bodies and, using 'lay ethnographer' accounts, show how these are mobilised in methamphetamine-related practice. In doing so, I illuminate the ontological politics of methamphetamine, suggesting the open and contested nature of this drug. My work is important as it challenges dominant ontological positions — such as that

methamphetamine is singularly toxic and dangerous, and that methamphetamine consumers user are inherently violent and psychotic — arguing that it is possible to research and understand this drug in ways that do not pathologise and further marginalise its users.

### **Chapter 3: Addressing ontological contingency; Assembling theory and method**

This chapter presents the theoretical framework and methodology that I apply to the study of methamphetamine and methamphetamine-related practices. I employ a theoretical approach that draws upon the work of post-structuralist scholars Michel Foucault and Gilles Deleuze as well as more recently published work by Nikolas Rose and STS scholars Bruno Latour, John Law and Ann Marie Mol. I use concepts developed by these theorists in order to critique the status of current knowledge around methamphetamine, and to challenge the very pejorative ways in which we understand people who consume this drug. Along with this theory, I use material—semiotics, a methodological approach congruent with these theoretical precepts. In this chapter I describe the key theoretical ideas that have informed my work and the methodology that I used in this research.

The theory and methodology I employ in my research enables me to address the ontological contingency of methamphetamine and methamphetamine-using subjects. First, I critique the way in which dominant discourses such as public health and biomedicine understand methamphetamine as destructive drug, and people who use methamphetamine as addicted or at risk of addiction, and consider their political effects. Second, a complex and nuanced study of this issue is undertaken such that an anterior pathologised and/or transgressive subject is not the site of investigation. Rather, the practices that produce and are produced by drug use are attended to through the accounts of people who consume methamphetamine and methamphetamine harm reduction/treatment providers. This opens up an exploration of the ways in which particular objects, subjects and spaces constitute methamphetamine and methamphetamine users. By doing so, it allows me to provide an alternative understanding of the relationships between these phenomena. My aim in assembling this account is to therefore provide other ways of thinking about the drug methamphetamine and those who use it — so that these subjects and objects are not manifested as fearful, pathological and inherently harmful — and to make visible methamphetamine-related phenomena that may be obscured and/or repressed in conventional accounts from science, policy and treatment.

In this chapter, I first present the theoretical concepts that frame this research. I then outline and discuss the methodological approach taken in order to fulfil the research objectives.

#### **Theoretical toolboxes: The work of Foucault and Deleuze**

This section presents the theoretical framework of my research. Here, I introduce the theoretical concepts that I use, providing a sense of their intellectual origins in post-

structuralism, and how they relate to more recent STS theory. I begin by introducing post-structuralism and the work of Foucault. I focus on the way in which Foucault, and later Rose, conceptualise power and knowledge and their constitutive role in the formation of human subjects. I then turn to Deleuze's theory of assemblages and the formation or 'becoming' of human and non-human entities and their relationality. Following from Deleuze, I show how STS later takes up these ideas through a material—semiotic approach to the world, and how this opens up the study of drug use. These theories move beyond the addicted drug-using subject and the reification of drugs to a more dynamic conceptualisation of reality, where reality is constituted through an array of practices, and can be multiple.

### **Post-structuralism and moving beyond the knowing subject**

Foucault and Deleuze were contemporaries and are regarded as belonging to a group of French thinkers loosely termed 'post-structuralists'. Foucault's respect for Deleuze's work is captured in the statement, 'Perhaps one day this century will be known as Deleuzian' (Foucault in Deleuze, 2006, p. vi). Likewise, Deleuze authored a highly regarded interpretation of Foucault's work (see Deleuze, 2006). Congruent with their understanding of the world, the relationship between their work is partial and fragmentary, and their bodies of work, taken either individually, or together, are not intended to provide totalising statements about existence. There are, however, broad themes common to both philosophers' work; both rejected rationalist and scientific accounts of history and nature that consider human civilisation as progressive and the natural world as immutable. Instead, they sought to find a more dynamic and fluid way of understanding existence.

Through their work, these scholars aimed to provide useable concepts that might be employed to instigate change, creating new possibilities (Foucault & Deleuze, 1980). This is captured in an exchange between Foucault and Deleuze where Deleuze explains, 'A theory is exactly like a box of tools...It must be useful. It must function', and then says 'A theory does not totalize' (Foucault & Deleuze, 1980, p. 208). This suggests that in order to 'practise' theory in the spirit of Foucault and Deleuze one should seek functional concepts that work in a local sense, rather than aspiring to be totalising and explanatory (Foucault & Deleuze, 1980). Remaining mindful of this, I discuss how I have used Foucault and Deleuze's work to inform my research.

## **Foucault's understanding of power and knowledge**

Foucault wrote extensively on the concepts of power, knowledge and discourse and their relationship to each other. His work demonstrates how power and control operate in modern, liberal societies, showing the ways in which individuals are governed and practices are shaped. Foucault contends that knowledge, or truth, is contingent and inextricably bound up with power. He argues:

power and knowledge directly imply one another ... there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault, 1991, p. 27)

Here, he argues that power is legitimised through knowledge, and that expertise (or knowledge) is productive of authority. Foucault used the concept of discourse — by which he means a set of practices, ideas, language and institutions that organise knowledge — to illuminate how power is exercised in modern liberal societies. Discourse is effectively what can and cannot be said, thought and done about a given population or issue. Thus it is productive of ways to understand oneself, other subjects and things, and it legitimises particular actions while marginalising others.

Foucault's critique of truth and knowledge makes possible the scrutiny of science and fact. Science becomes political — considered a series of practices and language that are constituted through power relations — instead of a body of knowledge that describes the natural world. In the modern world, scientific discourse has acquired the status of truth through these power relations; that is, the relationships between this field of knowledge and various institutions and mechanisms (Foucault, 1978). Moreover, as scientific discourse is highly authoritative, it legitimises associated discourses (such as public health). At the same time, this marginalises other discourses — or other practices and ways of thinking. These discourses then become forms of subversive knowledge. For instance, scientific discourse overwhelmingly produces drugs as inherently harmful and addictive, but there are other ways of thinking about drugs, such as within dance culture or party drug culture (see, for example, Pennay, 2012); these are subversive discourses that produce drug use as pleasurable and as a legitimate recreational activity.

Thus, myriad discourses exist at a given time, with a range of relationships and connections to each other. Foucault argues that while multiple discourses are in play, these are shaped by broader forces. He names these broader forces the ‘episteme’ and describes this as follows:

This episteme may be suspected of being something like a world view, a slice of history common to all branches of knowledge, which imposes on each one the same norms and postulates, a general state of reason, a certain structure of thought that the men of a particular period cannot escape — a great body of legislation written once and for all by some anonymous hand. (Foucault, 1972, p. 191)

Discourses therefore emerge through specific conditions of possibility and, as such, have commonality. They are shaped by the overarching norms of a particular historical moment. This, at the time Foucault was writing, was the ‘modern episteme’ (Law, 2004, p. 35).

### **The subject: How we understand ourselves in neo-liberal societies**

As well as helping us to conceptualise the contingency of knowledge and its relationship to power, Foucault’s work is important in terms of illuminating the ways we understand and constitute ourselves. Foucault rejected accounts of power as solely a repressive, exterior force bearing down upon the human populace. He conceived of the relationships between power, knowledge and discourse as also productive. Discourse makes available particular subject positions, and power is exercised when these subject positions shape the way that people act upon themselves and towards others. These subject positions are not static or essential in nature, as Foucault viewed subjectivity as both fluid and multiple, such that there is no ‘subject of enunciation’ (Deleuze, 2006, p. 47). What is said, Foucault argued, ‘is not said from anywhere’ (1972, p. 122). Deleuze (2006) describes Foucauldian subjectivity thus:

The subject is a variable, or rather a set of variables, of the statement. It is a function derived from...the statement itself...the subject is a place or position which varies greatly according to its type and the threshold of the statement, and the author himself is merely one of these positions in certain cases. A single statement can even have several positions. (p. 47)

Here, Deleuze argues a Foucauldian subjectivity is located within discourse and so produced through power. Further, he explains that this subjectivity is multiple and without foundation.

In terms of control of the populace, Foucault explores ways that power had shifted over the ages and that, while it may appear that in modern times less control is exercised over individuals, this is an illusion. Forms of power have changed rather than dissipated. Foucault

makes this argument by tracing the emergence of different types of control and their relation to the 'state'. He argues that in pre-modern times power was enforced through 'corporeal' forms of punishment (Foucault, 1991, p. 19), where the state exercised power directly on the body, in full view of the populace, by methods such as public floggings and hangings. This later shifted to forms of 'carceral' punishment, where power was exercised through confinement, such as imprisonment and forced labour (Foucault, 1991, p. 293). Through carceral forms of power, the body itself was no longer directly acted upon but was 'caught up in a system of constraints, privations, obligations and prohibitions' (Foucault, 1991, p. 11). Carceral punishment was no longer a public spectacle, and prisoners were typically kept from public view. Foucault argues that power still exists in a carceral sense and this is evidenced in the existence of modern-day prisons. However, he claims that power has also emerged in modern societies as a force that controls individuals by compelling them to self-regulate. This means that while individuals are still controlled through carceral measures (or the threat of these) they are also obliged to self-govern. Foucault (1978) conceived of power in this sense as 'bio-power'. Bio-power requires individuals to monitor and transform themselves as they 'qualify, measure, appraise and hierarchise' themselves against 'the norm' (p. 144):

One would have to speak of *bio-power* to designate what brought life and its mechanisms into the realms of explicit calculations and made knowledge-power an agent of transformation in human life. (Foucault, 1978, p. 143)

At the same time as bio-power shapes the actions of individuals, the construction of subject positions and norms enables the categorisation and therefore governance of populations (Fairclough, 1989; Foucault, 1972). For example, within Australian drugs discourse the subject position of 'the addict' is governed variously through drug treatment, public health measures such as needle and syringe programs (NSPs) and/or incarceration (Mugford, 1993).

### **The neo-liberal subject and emerging technologies of the self**

Rose (2000, 2007) has extended Foucault's ideas of power and the subject, addressing the obligation of 'self-government' in the neo-liberal (or advanced liberal) episteme (Dean, 2009; Rose, 2000). While Foucault's work referred to the governance of citizens within what can be considered a liberal state, Rose examines the implications of governance with the formation of the neo-liberal state. This is characterised by the:

[w]idespread recasting of the ideal role for the state, and the argument that national governments should no longer be guarantor and ultimate provider of security: instead the state should be partner, animator, and facilitator for a variety of independent

agents and powers, and should only exercise limited powers of its own, steering and regulating rather than rowing and providing. (Rose, 2000, pp. 323-324)

Thus, as the state continues to withdraw from a provider role, its power no longer centralised, new ways of controlling, regulating and governing citizens is necessary. Citizens are recast as 'self-governing' and, as a result, are 'autonomised' and 'responsibilised' (Rose, 2000).

Rose argues that with the changing role of the state, and subsequent shifts in the way that power is exercised, the way in which individuals constitute themselves has shifted. Through the autonomisation and responsibilisation of citizens, the self becomes the object of surveillance, and the exercise of free will and control — with the agency these entail — is valorised. The individual is obliged to 'assemble one's identity as a matter of one's freedom' and to 'render one's existence meaningful as an outcome of choices made' (Rose, 1999, p. 272). 'Self-empowerment' is a responsibility in that individuals are expected to take control of their lives and accept accountability for all their life choices. Rose (1999) argues:

The self is not merely enabled to choose, but obliged to construe a life in terms of its choices, its powers, and its values. Individuals are expected to construe the course of their life as the outcome of such choices, and to account for their lives in terms of the reasons for those choices. (p. 231)

A consequence of this shift to autonomisation and responsibilisation is that those without sufficient means or desire to mould themselves in the image of the neo-liberal citizen — to become self-empowered — are 'non-citizens, failed citizens, anti-citizens' (Rose, 2000, p. 331). Further, Rose (2000) claims that:

problems of problematic persons are reformulated as moral or ethical problems, that is to say, problems in the ways in which such persons understand and conduct themselves and their existence. (p. 334)

By conceiving of problems as related to conduct, non-citizens are seen as ultimately responsible for their own status. They have failed to conduct or understand themselves correctly. Problems they experience — such as poverty, joblessness or drug addiction — are because they have made the wrong choices. This effectively relieves the wider community, and the state, of responsibility for these problematic persons.

'Choice' then, is the central obligation of the neo-liberal subject. 'Psy' disciplines, including psychology, psychotherapy, psychoanalysis and practices such as cognitive behavioural therapy (CBT), are integral to providing choice-making citizens with the language and



practices to understand and constitute themselves in modern Western societies (Rose, 1999). Rose (1999) argues that the ‘psy’ disciplines are consistent with the concept of the neo-liberal subject, and governance of the self. These therapies are technologies of the self, and involve learning techniques of ‘self-reflection, self-knowledge and self-examination, for the deciphering of the self by oneself’ (p. 245). Therapeutic practices might include confession to a professional in a non-judgemental environment, narrative therapy where people make sense of current issue through past events, and even self-help literature. These therapies provide those individuals ‘unable to bear the obligations of selfhood’ with the techniques to restore their ‘capacity to function as autonomous beings in the contractual society as the self’ (Rose, 1999, p. 231). Thus, these disciplines are productive of citizens who are ‘free to choose’ as they assist citizens to learn to make the ‘right’ choices (Rose, 1999, p. 232). However, Rose argues that this liberation is double-edged. With the freedom to choose our own lives, we are obliged to undertake constant evaluation of ourselves, never free from working on the ‘project’ of our own identity (Rose, 1999, p. 258).

More recently, Rose (2007) argues that new developments in contemporary biomedicine have placed even greater obligations on individuals, and provided increasing technology with which they must constitute themselves. He sees these new fields of biomedicine as productive of new types of citizens, producing:

certain kinds of being whose existence is simultaneously capacitated and governed by their organisation within a particular field. (Rose, 2007, p. 20)

Thus Rose sees individuals as not only controlled and governed by emerging health practices, but enabled and *capacitated* by these. An overarching requirement of biomedical developments is that we understand ourselves in increasingly biological terms. Rose calls the reformulation of the citizen the ‘biological citizen’. This citizen is compelled to use biological and neurological understandings of the body to make decisions that maximise his or her *current* health as well as his or her *future* well-being (Rose, 2007). Rose explains:

Activism and responsibility have become not only desirable but virtually obligatory — part of the obligation of the active biological citizen, to live his or her life through actions of calculation and choice. Such a citizen is obliged to inform him or herself not only about current illness, but about susceptibilities and predispositions. Once informed such an active biological citizen is obliged to take appropriate steps, such as adjusting diet, lifestyle, and habits in the name of minimisation of illness and maximisation of health. (p. 147)

Rose is arguing here that, with emerging technology and information, the biological citizen is required to take in more information and make more choices about their present and future well-being. An outcome of the obligation to make increasing choices is that it produces ‘new types of problematic persons’ (Rose, 2007, p. 147). That is, those that cannot, or will not, undertake the practices of the biological citizen (Rose, 2007).

Rose (2007) uses the field of neurology as an example of an area that is productive of new ways in which to understand disorders, disease and oneself. He notes that developments in neurology have resulted in the reformulation of an increasing number of conditions as diseases of the brain (such as addiction). He argues that, with increasing technologies and developments in the area of neurology, people are obliged to understand and act upon this understanding. Explanations of how methamphetamine works in terms of its impact on the brain — often with an accompanying diagrams or animations (see, for example, *meth.org.au*; *bluebelly.org.au*) — are an obligatory part of methamphetamine resources for users or potential users. Neurobiological explanations of methamphetamine use focus on the production of dopamine. They assert that methamphetamine use causes the release of the ‘monoamine neurotransmitters’ (Barr et al., 2006, p. 302) (principally dopamine) from brain cells. This can result in initial feelings of euphoria, well-being and alertness. According to neurological discourse, consistent release of these neurotransmitters will eventually result in the production of ‘free radicals’ that then damage the brain cells containing dopamine (Barr et al., 2006, p. 303). The emphasis on methamphetamine and its relationship to the brain obliges those who use the drug to understand themselves as ‘neurobiological citizens’. Further, those who continue to use methamphetamine despite knowing the impact of this drug ‘neurally’ are constituted as failed citizens. These are individuals who, despite the science, are making the wrong choices — putting themselves at risk of neural damage.

### **Citizens and choice: Understanding agency and control**

In addition to addressing the obligation of choice, and emerging technologies of the self, Rose’s work also helps to understand the ways in which addiction and agency are conceptualised in the modern world. As I have shown above, Rose (1999) argues that citizenship is primarily realised through acts of ‘free but responsabilised choice’ (p. xxiii): The neo-liberal individual is considered as the sole agent in his or her life. He or she is required to exercise control over his or her desires and functions. Yet, drawing on Foucault, Rose’s work shows us how the *capacity* for agency — and choice and self-control — is

produced within various fields, such as the ‘psy’ disciplines and neurobiology. These bodies of knowledge and their related practices are constitutive of our sense of self, of control (or not) and freedom.

This way of conceptualising agency is illuminative in the area of drug use and addiction and other scholars have also explored the complexities of addiction in societies where we are ‘obliged to free’ (Rose, 1999). Eve Sedgwick (1992) argues that the late 20th century is characterised by an ‘epidemic of addiction-attribution’ (p. 587) and claims that ‘any substance, any behaviour, even any affect may be problematised as addictive’ (p. 584). Moreover, addiction is the state of being produced within absolutes; ‘absolute compulsion’ and ‘absolute volition’ (p. 586). Thus addiction is a failure of free will, where:

Addiction...resides only in the structure of a will that is always somehow insufficiently free, a choice whose volition is insufficiently pure. (p. 584)

This has effectively resulted in a crisis of agency. *All* our choices and practices must be scrutinised to determine if they are truly voluntary. Sedgwick (1992) argues that this means that:

detecting the compulsion behind everyday volition is driven, ever-more blindly, by its compulsion to isolate some new, receding but absolutised space of *pure* voluntariness’. (p. 586)

Pure voluntariness is a space from which we make choices that are driven by our true selves. These choices must be untarnished by compulsive exterior forces and are central to the constitution of the neo-liberal subject. Helen Keane (2002) clarifies that while Sedgwick’s conception of addiction residing in the structure of the individual will is insightful, *drug* addiction requires additional clarification. She argues that drugs are unique in that they are conceived as ‘powerful, artificial and foreign’ to the body (Keane, 2002, p. 24). Thus while drug addiction can be defined in modern societies as a ‘disease of the will’, addiction is very much a somatic state, and this is intrinsic to the way we understand the drug-addicted self.

The work of Foucault, and later Rose, brings to light the way in which power is legitimised through discourse. In my research, I draw upon their theoretical insights in order to interrogate scientific knowledge on methamphetamine and also to address treatment, policy and media discourse in terms of the subjectivities they make available for people who use methamphetamine. I also use the concept of self-governance to attend to the way in which people who use drugs constitute themselves and are, in turn, constituted through practices of

drug use, including harm reduction and treatment practice. In terms of drug use, the obligation of self-governance and choice reveals the way agency is constructed in a voluntariness/compulsive binary (and other absolutes) that underpins Western liberal societies (Sedgwick, 1992). For example, people who use drugs are constituted as choice-making citizens through practices such as NSPs and opioid substitution therapy (OST). Yet, at the same time, they are produced as addicts — individuals whose agency and choice-making capacity has been compromised — and thus they lack the defining attributes of the neo-liberal citizen. In this way, the theories of Foucault, Rose and Sedgwick illuminate the very limited ways in which we currently understand humanity and the implications these have for people who use drugs.

### **Deleuze's conception of humans, non-humans and their relations and effects**

Along with his regular collaborator, Felix Guattari, Deleuze also developed theoretical concepts that can be used to illuminate practices related to drug consumption. While Foucault's work is helpful for considering the status of knowledge and the ways in which people constitute themselves in relation to knowledge, Deleuze's work emphasises the relationality and fluidity of existence and the expressivity of human and non-human entities. He saw the social and material world as constituted through their connections, interactions and relationships. Applying these ideas provides new possibilities for conceiving of drug use. As noted in my literature review, it allows us to view drug use practices as constituted through the relationships of an array of objects, subjects and spaces, rather than solely in terms of drug users and their relationship to the fixed substance methamphetamine.

Differences between the work of Foucault and Deleuze are apparent in the way in which they consider the subject. While Foucault conceives of subjectivities as produced through power, Deleuze sees desire as a productive force. Deleuze also conceives of the 'pre-existence' of subjectivities (Colebrook, 2002a) — that is, of a world prior to becoming. Deleuze conceptualised this state of pre-existence as the 'plane of consistency' (Deleuze & Guattari, 1987, p. 589). Deleuze posits that desire is 'a process of production without reference to any exterior agency' (Deleuze & Guattari, 1987, p. 154) where desire is a force of connection, expansion and creation (Colebrook, 2002b). Conceiving of desire in this way, Deleuze sees subjects and bodies as formed through the result of desiring and the connections that they

make. For instance, a body desiring a drug may be an intoxicated body, yet the same body may be a mother due to its desiring relationship to a child.

Deleuze depicted essentialist, or closed, subjectivity as oppressive, rejecting this idea as ‘nailed down’ to a ‘dominant reality’ (Deleuze & Guattari, 1987, pp. 159-160).

Understanding the subject in this way entails a static view of the world, as the whole and complete subjectivity — or singular organism — is passive and unamenable to change. Instead, Deleuze seeks to understand human existence as dynamic and active. To do so, he conceives of the body as always understood through its connections with other entities. He aims for:

opening the body to connections that presuppose an entire assemblage, circuits, conjunctions, levels and thresholds, passages and distributions of intensity, and territories and de-territorialisations measured with the craft of a surveyor. (Deleuze & Guattari, 1987, p. 160)

Here, the human body is a series of assemblages (rather than a singular organism) always in the state of fluid becoming, rather than static being. Enmeshed within assemblages, the body is always being produced by desiring, interactions and connections with other bodies, things and assemblages. At the same time, the body is productive of these assemblages and connections.

Thus, Deleuze does not focus on what the body *is*, rather he sees the body in terms of its relations and connection with other entities. The body’s physicality, while necessary, is only one aspect of subjectivity and not privileged. According to Nick Fox (2011), Deleuze’s assemblages and their relations can be understood as follows:

The relations can be drawn from any of the domains, material or non-material, but in each case, the assemblage is dynamic not static: it is about the embodied process of eating or working or sexual desiring, not about a state of being. Furthermore, the assemblage will vary from person to person, contingent on the precise relations that exist as a consequence of experience, beliefs and attitudes, or from bodily predispositions. (p. 362)

Thinking of the body in this way is useful for considering drug use. Keane (2002) argues that, for the becoming body, an encounter with drugs is not necessarily ‘radically other and inherently damaging’, as rejecting a conception of the body as a biological and singular entity implies that there is no pure or natural state of biology or being (p. 35). We typically assume

there is an ideal biological state for each body and that the consumption of drugs (as toxic substances) interrupts and corrupts this state. Yet, considering the body as ‘becoming’ and as more than its physical self enables a more nuanced interpretation of drug use. Keane (2002) argues:

Although each body/drug encounter could be judged positive, negative or neutral depending on its specific effects, the encounter between the two bodies itself would not be assumed to be intrinsically bad. (p. 35)

Thus, a Deleuzian approach to embodiment leads away from the study of drug use in terms of the actions of an anterior, pathologised subject or a stable, toxic drug. In turn, this allows us to consider this issue in ways that are not reliant on pejorative understandings of people who use drugs or panics about substances, by actually attending to the lived effects of drugs.

Linked to this understanding of the body as a series of assemblages is Deleuze’s conception of the non-human world. Deleuze was equally concerned with the formation of matter and non-humans, viewing the world as self-organisational and expressive:

not only do plants and animals, orchids and wasps sing or express themselves, but so do rocks and even rivers. (Deleuze & Guattari, 1987, p. 44)

He argued that the expressivity of matter and structures is evident through ‘the organisation of their own specific form, and substances insofar as they form compounds’ (Deleuze & Guattari, 1987, p. 43). Thus, for Deleuze, expressivity and experience are not solely human domains — they are equally applicable to non-humans and objects. The theorisation of the expressivity of the material world allows a nuanced understanding of the objects of drug use. Here, the tools used to consume drugs and to treat drug use, and the spaces in which these practices take place, can be considered not only as conduits to disease, wellness, intoxication and so on, but in terms of how they constitute, and are constituted by, drugs and people who use drugs in consumption and service provision encounters.

Conceiving of the world using Deleuzian concepts entails the rejection of essentialist ways of knowing humans and objects. It involves attending to a different object of study: the assemblages that constitute a fluid and dynamic world. Moreover, Deleuze’s work provides alternative ways of being from those available in a progressive, teleological and anterior account of the world. He shows how becoming or embodiment is a political exercise, in which certain forms of becoming are possible, dependent on the connections, relationships and entities available. Thus, a subject’s capacity and attributes — such as its choice-making

potential, its self-control — are a product of these connections. In this way, Deleuze, like Foucault, does not begin his critique from the stance that there is an ideal state of humanity which is currently oppressed, rather, he interrogates the forces that *produce* subjectivities in order to understand specific human experiences, as well as the way in which power and control operates in the modern world.

### **Disrupting ‘truth’: Scrutinising scientific practice**

Foucault and Deleuze turned their attention to the field of science in order to critique concepts such as power, rationality and progress (see, for example, Deleuze & Guattari, 1994; Foucault, 1978). STS is an area of study that furthers this work, contributing to the post-structuralist project of critiquing modernity through the scrutiny of scientific practice. Generally, STS scholars reject the assumption that scientific knowledge is value-free. They see:

science as a social undertaking like any other, neither more detached from the cares of the world nor more universal and rational than any other practice. (Stengers, 2000, p. 1)

Many STS scholars, including Bruno Latour, John Law and Annemarie Mol, use both Foucauldian and Deleuzian concepts in order to further develop their theories.

STS’s preoccupation with the status of scientific knowledge and reality is valuable when studying methamphetamine. Science plays a key role in how we know the drug ‘methamphetamine’. The materiality of methamphetamine and its effects on the human body, both physical and social, is the focus of a large body of scientific literature. The resulting evidence about methamphetamine is integral to the manner in which this drug is dealt with in law, policy and practice.<sup>5</sup> STS offers invaluable theoretical insights for addressing and critiquing this body of knowledge and examining its relationship to the actual practices of drug use and service provision. Further, in foregrounding practice, STS makes assertions about the ontological contingency of the world. These assertions open up the possibility of change in a field that currently understands drugs and drugs users in very conventional and pejorative ways. In the following sections I review the work of several STS scholars in relation to knowledge and reality, and outline some of the theoretical concepts that they have developed. I do so in order to show how this work can be usefully applied to drug consumption and harm reduction/treatment practices.

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<sup>5</sup> For example, Australian national policy on drugs makes a ‘strong commitment to...evidence- informed practice, innovation and evaluation’ (Ministerial Council on Drug Strategy, 2011).

## **Inscription devices and the practice of science**

Facts are generally considered to be statements that reflect or describe reality, produced through the field of science (Latour & Woolgar, 1986). As a ‘proven’ form of knowledge, facts are defined in opposition to local, ‘unproven’ forms of knowledge. Methamphetamine (as with many illicit psychoactive substances) is the object of much scientific investigation, the results of which are reported in scientific texts. These results are ‘facts’— irrefutable knowledge about methamphetamine. This is, of course, not the only body of knowledge about methamphetamine. Many people have had experiences with this drug, and therefore ‘local’ forms of knowledge about methamphetamine also exist. This type of knowledge is not accorded the status of scientific knowledge as it has not been produced through the purportedly rational exercise of scientific practice. In claiming that scientific knowledge is contingent and constructed, however, STS rejects this scientific/local binary, and treats both forms of knowledge in the same way.

STS scholars Latour and Woolgar (1986) undertook careful observation of scientists’ working practices in a seminal ethnographic study at a scientific laboratory in France. Their research illuminated ‘the daily activities of working scientists [that] lead to the construction of scientific facts’ (Latour & Woolgar, 1986, p. 40). ‘Facts’ here are not descriptions of a pre-existing reality; rather, they are crafted through the practices of science where creating facts involves the inscription of materiality (Latour & Woolgar, 1986, p. 236). Latour and Woolgar (1986) refer to the processes or mechanisms by which reality is inscribed as ‘inscription devices’ (p. 51). These are the apparatuses used in scientific practice to translate materiality into useable data, that is, data that can be used in written documents to make the case for the establishment of a particular fact. Moreover, the data that inscription devices produce are assumed to have a direct relationship to the ‘original substance’ (Latour & Woolgar, 1986, p. 51). This means that even though data may take the form of charts or series of numbers, they are still considered manifestations of materiality.

As part of the process of constructing facts, ‘inscriptions’ are presented in peer-reviewed journal articles. This allows scientists to ‘make points in the literature on the basis of a transformation of established argument into items of apparatus’ (Latour & Woolgar, 1986, p. 66). The act of publishing is therefore a form of ‘literary inscription’ (Latour & Woolgar, 1986, p. 76) and an important stage in the construction of fact. Latour and Woolgar (1986) argue that there is ‘an essential congruence between a “fact” and the successful operation of various processes of literary inscription’ (p. 76). In order for a fact to materialise, all evidence



of its inscription process must disappear, and a shift must occur ‘whereby an argument ha(s) been transformed from an issue of hotly contested discussion into a well-known and noncontentious fact’ (Latour & Woolgar, 1986, p. 76). Conversely, Latour and Woolgar (1986) note that a statement is also understood as fact by reference to the process of literary inscription. Through citation and repetition, ‘scientific fact’ is constructed. They argue that through publishing facts in journals, and then citing these facts to establish further facts, peer review and publication operate as an essential stage in the craft of science. Journal articles are the currency of science, and considered the basis of fact.

Latour and Woolgar’s (1986) work builds upon Foucault’s concepts of discourse and power, theorising how knowledge is made. By scrutinising the practices undertaken by scientists in order to produce claims about the natural world, these scholars argue that large heterogeneous networks and relations are required to produce apparently natural facts. By illuminating the constructed nature of facts, they demonstrated the way in which the traces of production are effaced, so that two distinct domains are produced: reality and knowledge of reality (Law, 2009). Thus, the anterior reality on which science relies is remade by Latour and Woolgar as a political illusion, and the contingency of what we know to be truth and reality is foregrounded.

### **Enacting multiple realities**

Following the work of Latour and Woolgar (1986), theorists Annemarie Mol and John Law contributed to a second wave of STS (Latour, 1999). Their work features a commitment to ontological symmetry where, following Deleuze’s understanding of existence, humans and non-humans are considered equally capable of expressivity or agency. These scholars seek to build upon the theory that facts and knowledge are constructed through practice, positing that reality itself is materialised through practice. Further, the work of Mol and Law is more explicitly political than that of Latour and Woolgar (1986), addressing very directly the issue of why some realities are possible and others are not.

Mol (1999) and Law (2004) extend Latour and Woolgar’s (1986) theory of the construction of facts by contending that reality itself is enacted through practice — scientific and otherwise. According to Mol (1999) ‘reality is manipulated by means of various tools in the course of a diversity of practices’ (p. 77). Further, Mol (1999) and Law (2004) reconsider the concept of ‘construction’ (used by Latour and Woolgar) by arguing that the concept of ‘enactment’ better captures the dynamic and fluid nature of the world, while also opening up

possibilities for political change (Mol, 1999, p. 77). Construction implies that ‘an object has been constructed’ (Law, 2004, p. 56) and therefore is closed, completed. This entails that there are no further possibilities; reality has ‘become’ something. Enactment, however, or practice better attends to the continuing processes of inscription:

Enactment and practice never stop, and realities depend upon their continued crafting — perhaps by people, but more often... in a combination of people, techniques, texts, architectural arrangements, and natural phenomena (which are themselves enacted and re-enacted). (Law, 2004, p. 56)

In asserting that reality is enacted, and re-enacted, through practice, Mol (1999) argues that reality is multiple. She claims that an object’s attributes vary according to practice, leading it to be defined in different ways. For instance, methamphetamine is a multiple object in that it is available in multiple forms including pills, ‘base’, powder and crystal. Each form is made through different practices, consumed in different ways, with purportedly different outcomes. But methamphetamine is also enacted in other ways. It may be smoked at a party for pleasure, snorted before work for wakefulness or injected into a rat’s brain for the purpose of scientific observation. These different tools and practices enact multiple and co-existing versions of methamphetamine, each with different effects. Thus, there is no essential, singular object ‘methamphetamine’ to be discovered beneath these descriptions. If we consider reality as performative, powder, base or crystal methamphetamine are not:

attributes of a single object with an essence which hides. Nor is it the role of tools to lay them bare as if they were so many *aspects* of a single reality. Instead of attributes or aspects, they are different *versions* of the object, versions that the tools help to enact. They are different, yet related objects. They are multiple forms of reality. Itself. (Mol, 1999, p. 77, emphasis in original)

In this statement, Mol notes that multiple forms of reality are not disparate; they are related to each other. (Law, 2004) interprets this idea as a ‘world of fractional objects’ where ‘a fractional object would be an object that is more than one and less than many’ (p. 62).

If we accept that there are multiple realities, (Mol, 1999) argues that we have a choice as to which realities we craft. She uses the term ‘ontological politics’ (p. 74) to describe this idea. Ontology concerns the nature of being and, if this term is then paired with politics, it suggests a politics of being in which the real is not given (1999, p. 75). Realities are crafted through practice. Different practices entail different realities and thus, in choosing which practices we

employ, we choose reality. These choices are always political as different realities have different effects. For example, the practice of incarcerating a person found to be in possession of illicit drugs creates prisoners, but also prisons, prison sentencing, guards and parole officers. If an alternative practice were employed to address this person's illicit drug possession, treatment for instance, a different reality would be enacted. This would include patients, treatment centres, doctors and treatment regimes. Importantly, Mol notes that the particular conditions of possibility — a concept she borrows from Foucault — shape realities (Mol, 1999, p. 80). This means that realities are always enacted in relation to political conditions and available discourses. In the example I have given above, the practices used to address illicit drug use are different — incarceration or treatment — yet they share assumptions about people who use illicit drugs. These assumptions include that this group of people need intervention and rehabilitation, they must cease drug use and they are not able to address their drug use without expert intervention. Other realities of illicit drugs — legislation and free access, for example — would require new conditions of possibility to emerge at this time.

Law (2004) similarly investigates the complexity of enacting knowledge, and why some realities materialise and others do not. Law argues that for a particular fact to come into being, it needs to fit in with 'a network of other statements, materials and practices' (p. 96). He refers to these networks as 'hinterlands' (Law, 2004, p. 27), and uses this concept to argue that realities are not crafted arbitrarily, rather they materialise in accordance with previously accepted truths and knowledge. Critical to any hinterland are inscription devices, a term Law (2004) extends upon, describing them as 'a set of arrangements for labelling, naming and counting' (p. 29). He sees the practice of science (and of any other body of knowledge) as involving the 'orchestration of suitable and sustainable hinterlands' (Law, 2004, p. 29). Speaking of scientific knowledge, Law (2004) argues that it is enacted through a 'single authorised set of inscription devices' (p. 32). These inscription devices produce a singular and anterior reality and, in doing so, obfuscate the multiple possibilities of materiality. In this sense, Law too, draws upon a Foucauldian sensibility, in which truth and knowledge are always political. The field of science has the authority to produce what we consider to be reality, and in doing so it shapes the way in which we think about the world.

I use the work of Law and Mol in my research to acknowledge that realities are enacted. First, this helps me to overcome a problem I identified in earlier work around methamphetamine panics. In some cases authors of these works were critiquing the social

construction of a panic, while asserting there was a ‘real’ problem of methamphetamine. Or, in the case of Ayres and Jewkes (2012), the authors argued that there was not a methamphetamine problem and deemed some bodies of knowledge to be an accurate reflection of reality (statistics for instance), while others were not (such as mass media). Second (and I will discuss this in greater detail later), Mol and Law’s work also enables me to acknowledge that my research is merely one account of methamphetamine.

### **‘Doing’ embodiment: Multiple selves**

If reality is enacted, then this has implications for subjectivity. Deleuzian scholars, such as Ian Buchanan (1997), and STS scholars have attended to ways in which embodiment is performed. These theorists conceive of subjectivity as enacted and re-enacted through practice, where there is no anterior, stable identity prior to practice. Buchanan (1997) addresses the ‘problem of the body’ in the work of Deleuze and Guattari, arguing that they provide an ‘ethological’ account of the body (p. 73). By this he means an account in which the body is seen as defined through practice, rather than practice being seen as the actions of, or a response to, a particular body. Buchanan (1997) argues that the ‘body in Deleuze is an *a posteriori* product of newly connected capacities’ (p. 75) and that in order to understand embodiment in a Deleuzian sense we must ask ‘What can a body do?’ Interrogating bodies in this way brings to light their various capacities, and, at the same time, the political nature of practice and embodiment is illuminated, as different practices capacitate bodies in different ways.

Mol and Law (2004) also conceive of the body as performed through practice, arguing that we ‘do’ our bodies through practice. That is, in our day-to-day practice we enact our bodies in different ways. Mol and Law’s (2004) theoretical impetus for conceiving of the body as something we ‘do’ is to subvert the binary that exists between the ‘body-object’ and the ‘subject-body’. Here, the ‘body-object’ is the body known by science and medical experts, a body that can be measured and assessed, manipulated and cured. The private ‘subject-body’ is the body that is experienced — ‘the fleshy situatedness of our modes of living’ (Mol & Law, 2004, p. 43). These scholars enquire into the ‘body-we-do’ in order to escape the self-evidence of this binary, but also to attend to the lived experience of health or non-health (Mol & Law, 2004, p. 57). By thinking of the body as something that we ‘do’ and foregrounding the practice of disease, the body is conceived as entangled with the disease/s it encounters. The practice of disease enacts certain subjectivities and, at the same time, subjects perform their disease. Further, the body is not a ‘coherent whole’, rather it is a ‘set of tensions’ where

tensions and competing interests exist between the various parts and organs of the body (Mol & Law, 2004, p. 54). This addresses the complexity of medical intervention in that, rather than enacting ‘pure improvement’, interventions introduce a new set of tensions to the body. A simple example of this is OST. On the one hand, people may find OST beneficial for certain parts of their body. They may reduce their injecting and so their vein health improves. On the other hand, they may find that they sweat more and become constipated. Thus, there is no pure gain from OST. Some parts of the body benefit, others do not.

Buchanan (1997) and Mol and Law (2004) address the way in which embodiment is performed through assemblages. These theorists understand bodies as enacted — and capacitated — through connections and relations they establish with other entities, both human and non-human. Buchanan uses the concept of assemblage to show us the capacities of bodies. Mol and Law (2004) use the idea of the ‘body-we-do’ to consider the way in which practices enact. In my research, I use Buchanan’s insights to describe how drug-using subjectivities are performed through texts, and ask ‘what can a body do?’ in order to address the political nature of the way in which policy, treatment and media texts constitute methamphetamine-using subjectivities. I use Mol and Law’s work to address the way in which individuals ‘do’ themselves through methamphetamine-related practices — such as consumption or harm reduction/treatment — and also to describe interventions into methamphetamine use in terms of the ‘sets of tensions’ they introduce to people’s lives. Both works allow me to consider the political nature of embodiment. Individuals embody themselves through practice, but the ‘conditions of possibility’, which operate at a given time, limit which practices are possible. This means that practice is always shaped by political forces. Showing how bodies are capacitated through practice enables me to illuminate the absolutes that underpin our understanding of drug users’ agentive capacity — such as voluntariness/compulsion, controlled/chaotic — and points to the inherently political nature of practice. Here, I again draw on Foucault and Rose to make visible the way drug users are enacted, or embody themselves, in relation to the obligation of choice and control that inform the broader cultural norms of neo-liberal societies.

The theoretical concepts that I have outlined in this chapter point to a complex and multiple reality and suggest the ontological contingency of the world. I employ these concepts to address my research questions; that is, to show the ways in which dominant discourses, such as science, policy, treatment and media, constitute the drug methamphetamine and the people who use this drug. Most scientific accounts of methamphetamine materialise this drug as a

singularly potent and addictive object; at the same time, these accounts enact drug-using subjects as deviant and/or pathological. STS challenges these accounts, allowing me to identify them as contingent upon the available hinterland of AOD knowledge and the inscription devices embedded within this. In doing so it creates other possibilities for understanding drug use. Building upon Deleuze's understanding of the world, STS rejects pre-existing ontological categories of nature and culture, seeing humans and non-humans as both constitutive of, and constituted by, the connections they make. Thus the practices of methamphetamine service provision and consumption can be analysed as multiple networks, always materialising particular subjects and objects of drug use. This enables the tracing of relationships between the object 'methamphetamine' and consumption and harm reduction/treatment practices, without assuming anterior categories such as 'addict', 'addictive substance', 'client' and so on. Instead, such entities are seen as *produced* through methamphetamine-related practices. These practices are always political, shaped by the contemporary conditions of possibility and have specific effects.

### **Researching multiplicity: Methodological considerations**

Undertaking research using the theoretical insights I have outlined above entails employing a methodology that can attend to the fluidity of objects and subjects, and focus on the performative capacity of the connections and relationships they form. In this section, I present two methodological concepts: a material—semiotic method that Latour (2005) espouses as a 'renewed' form of empiricism, and Law's (2004) 'method assemblage' — a concept that assumes the performative capacity of method. I define and discuss these two concepts and how I use them. Then, using insights from both these scholars, I discuss how my research practice can attend to the messiness of the world, without 'making' a singular and oppressive reality. Finally, I present my method and discuss some of the implications of my approach in light of the issues raised by Latour and Law.

### **Actor network theory (ANT) and matters of concern**

ANT is a well-known form of material—semiotic methodology. This approach considers the 'relationality of entities, the notion that they are all produced in relations, and applies this ruthlessly to all materials' (Law, 1999, p. 4). Law (2004) gives the following definition of ANT:

Actor network theory is a disparate family of material—semiotic tools, sensibilities, and methods of analysis that treat everything in the social and natural worlds as

continuously generated effects of the webs of relation within which they are located. (Law, 2009, p. 141)

In terms of the practice of ANT, Law states:

The actor network approach thus describes the enactment of materially and discursively heterogeneous relations that produce and reshuffle all kinds of actors including objects, subjects, human beings, machines, animals, ‘nature’, ideas, organizations, inequalities, scale and sizes, and geographical arrangements. (Law, 2009, p. 141)

ANT enables a symmetrical approach to research, whereby humans and non-humans are accorded the same significance and their relationships to each other scrutinised. Moreover, as Latour argues, by using the concept of ‘network’ and tracing a ‘trail of *associations* between heterogeneous elements’ (Latour, 2005, p. 5, emphasis in original) we ‘render the movement of the social visible’ (Latour, 2005, p. 128). Eschewing structural explanations of power or ‘the social’, ANT makes visible localised power arrangements and the lived effects of inequity by describing networks and the relationships between entities. In my research I employ an ANT approach, finding it valuable in the way it enables me to attend to the relationality of human and non-human entities and the practices of drug use and harm reduction/treatment. I also find it helpful in illuminating the lived effects of various power arrangements such as an individual’s encounter with a treatment agency.

Through using ANT, Latour urges researchers to ‘get back to empiricism’, ‘follow the actors’ and to ‘go back to the object’ (Latour, 2005, p. 146). Here, Latour commits to specificity and description, rather than totalising and final statements about reality. This echoes a primary theoretical concern of Foucault and Deleuze, that of localised and specific responses, a ‘micro-politics’ of existence (Colebrook, 2002b, p. 92), rather than explanatory and absolute theories of the world that ‘nail down’ reality. Latour (2004) argues that scientific research produces facts: totalising statements that reify the world in knowable ways. As he puts it, while facts are certainly related to the material world:

Matters of fact are only very partial...very polemical, very political renderings of matters of concern. (Latour, 2004, p. 232)

Latour draws on a Foucauldian understanding of knowledge here. He asserts that facts — the body of knowledge that informs what we can do, say or think about the world — are a specifically political representation of the world. Yet, in critiquing facts Latour seeks not to

deny their relationship to the material world but to extend upon it. This requires a renewed form of empiricism to interrogate facts, and expand upon them, turning matters of fact back into what he calls collective ‘matters of concern’. Studying ‘matters of concern’ thus requires *expanding* our understanding of issues so that they become ‘intrinsically political’ (Fraser, 2011, p. 95). Taking my lead from Latour, my aim in this research is to address methamphetamine as a ‘matter of concern’, rather than a ‘matter of fact’. This is not to refute the material effects of methamphetamine, or to ‘disprove’ the ‘facts’. Instead I aim to understand the materiality of methamphetamine in a more nuanced, complex and expansive way than the ‘facts’ of methamphetamine currently allow.

### **Method enacts**

While Latour (2005) conceptualises ANT as an approach that addresses the problem of method, Law (2004) attends to this issue through the concept of method assemblage (p. 161). This is a more explicitly political approach to method that acknowledges that research practice makes certain realities present and others absent. Law (2004) argues that methods of data collection such as observation, online surveys, individual interviews and focus groups act as inscription devices. As such:

method does not ‘report’ on something that is already there. Instead, in one way or another, it makes things more or less different. (Law, 2009, p. 143)

Conceived in this way, sociological research is not a neutral practice. As with all other practices, it involves enacting particular realities. Law (2004) argues that most sociological research is shaped by ‘Euro-American common sense realism’ (p. 143), that is, it sees research practice as descriptive, and methods as tools to ‘collect’ data that then represent a singular, definite, anterior reality. He argues:

Realities are produced along with the statements that report them. The argument is that they are not necessarily independent, anterior, definite and singular. If they appear to be so (as they usually do), then this is itself an effect that has been produced in practice, a consequence of method. (Law, 2004, p. 38)

Thus, as with scientific practice, most sociological research produces a singular version of the world, obfuscating the multiplicity of reality.

Law (2004) defines a method assemblage approach to research as one that addresses an ‘interactive, remade, indefinite and multiple’ world (p. 122). This involves:



the process of crafting and enacting the necessary boundaries between presence, manifest absence and Otherness. Method assemblage is generative or performative, producing absence and presence. (Law, 2004, p. 161)

Here, a method assemblage approach is one that makes explicit the ways in which method constitutes realities. All research makes present objects, subjects, practices, spaces and effects. Yet with presence comes absence and Law argues there are two forms of this — manifest absence and Otherness. He clarifies that:

manifest absence is that which is the ‘necessary Other’ to presence, what is made absent, but recognised as relevant to presence. (Law, 2004, p. 157)

Thus, this is what is manifest in its absence — objects and subjects and other phenomena that correlate to presence (Law, 2004, p. 84). Otherness, on the other hand, is absence that is *not* made manifest; it is what disappears or is repressed with absence (Law, 2004, p. 162). Law explains that sometimes what is othered is routine and insignificant. Sometimes, however:

what is being brought to presence and manifest absence cannot be sustained unless it is Othered. (Law, 2004, p. 85)

Here Law sees a method assemblage approach as acknowledging the political of research; that it makes present some realities and, in doing so, will repress and other alternative accounts.

As already noted, in much scientific research on methamphetamine, the drug is made present as an addictive and destructive substance. Necessary and relevant to this presence are contexts such as treatment centres, practices such as rehabilitation and subjects such as addicts. These entities might be absent from particular statements or accounts that concern the addictiveness of methamphetamine, but they are made manifest in that they are a necessary part of addiction. At the same time, other phenomena are othered in order to make methamphetamine in this way. Addiction in the current conditions of possibility is a practice devoid of pleasure and functionality; it is a singularly compulsive and pathological activity. Therefore concepts such as pleasure or functional use of methamphetamine are othered. So too are subjects such as individuals who take this drug for pleasurable reasons, on an intermittent basis, experiencing no harm.

Enacting the boundaries between presence, manifest absence and Otherness requires that the arrangements of method assemblage are unavoidably political. They produce ‘truths and non-truths, realities and non-realities, presences and absences’ (Law, 2004, p. 143). This means

that rather than implying a set of specific methods, method assemblage is about being cognisant and reflective of practice, committing to enacting realities that are not oppressive — ‘to make some realities realer, others less so’ (Law, 2004, p. 67).

### **Reality is ‘messy’: How to attend to it**

If we understand the world as ‘interactive, remade, indefinite and multiple’ (Law, 2004, p. 122) how, in practice, do we attend to it? Doing justice to the complexity and multiplicity of reality is no easy task. Law (2004) notes that in addressing ‘messiness’ and the overwhelming nature of reality, one must find patterns, ‘bundle’ them and make a story. And in order for these patterns and stories to make sense, they must be situated within a theoretical context. The process of theoretically locating one’s data involves interaction between theory and data as these resonate and amplify one another ‘to produce pattern and repetition’ (Law, 2004, p. 111). This process is academic, but it is also creative:

Scientists (and other people too) creatively detect and select appropriate similarities between instances whilst ignoring others [...] Inscription devices make traces which sometimes map on to one another to produce a sustainable set of similarities. Again, the metaphor is about the need to find or make a pattern against an endless background of noise. (Law, 2004, pp. 108-109)

Here, Law argues that the creative exercise of identifying patterns, situating them appropriately, and telling a story is common to *all* research. Research underpinned by ‘Euro American common sense realism’, however, obfuscates these processes as it claims it is ‘objective’ and ‘neutral’. In doing so, this research crafts singular outcomes, making multiplicity absent. Employing a method assemblage approach entails that these processes are explicated and messiness and multiplicity are revealed.

Both Latour and Law argue that research is an intuitive, reflexive and descriptive process. Researchers produce objects of study through their practice, and then make choices about the ways in which they follow these objects through their data. The research findings will recognise the multiplicity of the objects of study, yet are only a partial rendering of this. Researching matters of concern aims to approximate the complexity of reality and rejects the need to produce incontestable knowledge about the world. Method assemblage is the process of exposing the political nature of and work involved in research practice. Further, a satisfactory account must address the political nature of multiplicity, describing the effects of

particular materialisations, and acknowledging the conditions of possibility that enable the production of particular realities.

Methamphetamine use and its treatment is situated in an AOD/scientific hinterland, comprising many research projects, practices, theories, policies, institutions and so on. By situating my work in post-structuralist and STS theory, employing a material—semiotic methodology and a method assemblage approach, I describe the ways in which methamphetamine and methamphetamine-using subjectivities are constituted, revealing some of the inscription devices involved and the hinterlands these are embedded within. I also examine methamphetamine-related practices — including consumption and harm reduction/treatment — and describe how individuals embrace and/or subvert these specific enactments. In doing so, I produce an account of methamphetamine that acknowledges the multiplicity and complexity of reality. However, congruent with understandings of the world as fragmentary and multiple, this account can only be a partial rendering of methamphetamine-related practices. In this spirit, I present the methodological tools I used in collecting data for this project, and the activities I undertook, in order to trace the effects of the object ‘methamphetamine’ and the practices of people who use this drug, as well as methamphetamine harm reduction/treatment practices. I show how these activities enabled me to address the ways in which dominant discourses, such as science, policy, treatment and media, constitute the drug methamphetamine and the people who use it.

### **Methodological tools**

I used three qualitative methods in conducting this research. These were:

1. A mapping exercise involving authoritative literature concerning methamphetamine in order to trace the textual enactments of methamphetamine and methamphetamine-using subjects in scientific, policy, treatment and media discourses.
2. In-depth interviews with people who use methamphetamine regularly and methamphetamine service providers in order to explore consumption and service provision practices productive of this drug and drug-using subjectivities (see Appendix B).
3. Field notes and diagrams made after interviews in order to describe the spaces within which harm reduction/treatment and consumption of methamphetamine takes place.

## **Methodological steps**

In this section I describe the key methodological steps I took in conducting this research. Although I attempt to place these steps in chronological order, the research process is necessarily flexible, reflexive, iterative and messy and, during the research, tasks usually overlapped.

1. I reviewed the epidemiological, public health and sociological literature concerning methamphetamine. Epidemiological and public health reports gave a sense of the scale of use and reported harms associated with methamphetamine. Combinations of the following key terms: ‘methamphetamine’, ‘amphetamine’, ‘dependence’, ‘addiction’, ‘harms’ and ‘treatment’ were used.

I also reviewed qualitative sociological literature to identify areas that were theoretically underdeveloped and also to identify problems in the knowledge to date. I used combinations of the following key terms: ‘methamphetamine’, ‘qualitative research’, ‘qualitative method’, ‘social construction’, ‘STS’, ‘post-structuralist’ and ‘ANT’.

2. Ethics approval was obtained from the Curtin University Human Research Ethics Committee (HREC) (approval number HR 54/2009).
3. I identified the geographical area in which I would conduct the research and I began the process of data collection. Five types of health and AOD services were identified in the area and chosen to take part in the research. These services were chosen on the basis that they represented a range of different treatment types and services for people using drugs (including methamphetamine). The services were approached through an introductory letter, followed by a telephone call. All services I approached agreed to take part in the research project.
4. I met with services individually to discuss their preferred method of client recruitment and how I would go about interviewing staff members. The research proposal was then submitted to two additional HRECs. These were St Vincent’s Hospital HREC A (Melbourne) (approval number HREC-A 120/09) and Eastern Health HREC (approval number E99/0910).
5. Thirteen in-depth, semi-structured interviews were conducted with workers from the services taking part in the research.

6. Twenty-eight in-depth, semi-structured interviews were conducted with people using methamphetamine, including people in contact with services and those who were not.
7. Authoritative texts were identified and analysed in order to map the ways in which methamphetamine is constituted in public discourse.
8. Interviews were professionally transcribed. I listened to each interview after transcription and ensured the transcription was accurate.
9. I entered all interview data into database management software (NVivo8™) and coded it.

In the sections that follow, I discuss these methods in more detail.

### **Textual analysis**

Given, as I have argued, discourse is productive of methamphetamine-related practices and the ways in which we understand methamphetamine and methamphetamine-using subjects, a mapping exercise was an important part of this research. In this exercise I described how methamphetamine and methamphetamine-using subjects were constituted in authoritative texts. By ‘authoritative’, I mean texts that contribute to dominant discourses such as biomedicine and public health. I examined the object ‘methamphetamine’ through scientific texts (see Appendix A), and methamphetamine-using subjects through policy, treatment and media texts. The selected texts are heterogeneous, differing in origin and intent, particularly in the case of media texts. However, they are similar in that they have been authored and/or produced by institutions with considerable power and authority and, as a whole, constitute an authoritative methamphetamine discourse.

The texts I analysed were separated for the purposes of a clear and easy-to-follow argument. In doing so, I do not mean to assume a linear reality where the scientific field produces knowledge which then informs other fields. Scientific knowledge, as much as any other field, is shaped and driven by the interests of significant individuals in the field, funding constraints, public concern and so on. However, separating the texts in this manner acknowledges, as Foucault (1978) has argued, that discourses are ‘hierarchised’ (p. 30). As the creators of facts that describe our natural world, scientists produce knowledge that usually trumps other forms of knowledge (Jasanoff, 2011). Consequently, texts that purport to be true must be based on scientific knowledge.

To map textual enactments of methamphetamine in scientific discourse, a literature search was carried out using Google scholar and the databases ScienceDirect, ProQuest and Medline using combinations of the following key terms: ‘methamphetamine’, ‘amphetamine’, ‘dependence’, ‘addiction’, ‘harms’ and ‘treatment’. I restricted my search to articles published between 1995 and 2010. This search strategy generated over 1000 articles. As my primary focus was the discursive production of methamphetamine in the Australian context, I focused my analysis on the subset of Australian scientific texts, except where these texts led me to literature that originated overseas. This was because while my focus was Australian texts, I was also interested in the extent to which these texts echoed, or contributed to, claims made in the international literature. Through careful reading of these texts, key claims or ‘facts’ regarding methamphetamine were identified. I define ‘key claims’ as those that are made repeatedly in the literature and/or that are prevalent in public discourse on methamphetamine.

In order to analyse these claims, I was guided by the work of Latour and Woolgar (1986) and their scrutiny of scientific practice. Articles were selected on the basis that they contributed significantly to a particular claim. That is, they presented evidence that was ‘proof’ of a particular claim. These texts were then carefully re-examined for contradictions in the cited evidence, inscriptions of methamphetamine’s materiality and instances of ‘literary inscription’ (Latour & Woolgar, 1986, p. 76). In some cases, additional searches were carried out. For instance, in some articles, a path of inscription was traced back through earlier publications cited as evidence for various claims about methamphetamine.

I selected other authoritative texts for their significance in the field. I analysed the national policy document that addresses methamphetamine, the *National Amphetamine-Type Stimulant Strategy 2008-2011*, the federally-funded treatment manual *Treatment approaches for users of methamphetamine: A practical guide for frontline workers* as well as *A brief cognitive behavioural intervention for regular amphetamine users* (Baker, Kay-Lambkin, Lee, Claire, & Jenner, 2003) and the website *meth.org.au*. I also analysed the documentary *The Ice Age*, televised by the national broadcaster, the Australian Broadcasting Corporation (ABC), in 2006. I scrutinised these texts in terms of the subject positions made available for people using methamphetamine. I considered these subjectivities in terms of the object ‘methamphetamine’ as it is discursively realised through scientific texts. I also considered these subjectivities in terms of their relationship to the ‘absolutes’ of drug use — such as

voluntary/compulsivity, controlled/chaotic — an understanding of drug use that is shaped within the neo-liberal episteme (Sedgwick, 1992).

### **In-depth interviews**

In addition to textual analysis, I undertook in-depth interviews to gather empirical data concerning experiences of methamphetamine-related practices such as harm reduction, treatment and consumption. Accounts of drug use were used to better understand people's relationship to the object methamphetamine, and the objects and spaces of drug use.

Accounts of drug harm reduction/treatment were collected to gain insight into the way in which these practices, and the spaces of drug service provision, shaped drug users and drug use. Overall, accounts were used to show the ways in which people incorporated, produced, embraced and resisted dominant enactments of methamphetamine. I discuss some of the epistemological and ontological implications of using in-depth interviews later in this chapter, but first I describe the groups of people I interviewed and their recruitment.

I interviewed 41 people in total, grouping these people in three ways:

- people who use methamphetamine and had recent contact with harm reduction and/or treatment services (n=15)
- people who used methamphetamine and had no recent contact with harm reduction and/or treatment services (n=13)
- harm reduction and/or treatment service providers (n=13).

### **Recruiting participants**

I recruited most of my participants from services located in an inner-city suburb in Melbourne, Australia's second largest city. Although in recent years the suburb has experienced gentrification, a lot of public housing remains, including a high-rise housing estate. This suburb has an array of services targeted towards low income earners, people who are homeless, people who do not have paid employment and people who use illicit drugs or alcohol. With a few exceptions, these services are concentrated in one area of the suburb, away from the café and retail precinct. I undertook research in this suburb because of the concentration of AOD services. Also, I had previously lived and worked in the area (at an AOD service) and was familiar with it. This meant I could easily identify the services I wished to recruit through, and often personally knew workers at the services. Further, I expected that with the mix of socially and economically privileged residents, as well as those

who were residing in government housing, I would have access to varying accounts of methamphetamine use.

Five types of services were approached in order to recruit service providers and people using methamphetamine. These services were NSPs, outreach programs, accident and emergency (A&E) care, primary health care, and AOD specialist treatment. Seven services were contacted in total. When services were initially contacted about taking part in the research, I asked to interview up to five workers and to recruit up to 15 users of the service.

### **Interviewing service providers**

Service providers were interviewed from six of the organisations approached. It proved too complicated to access A&E workers who might provide services to people who use methamphetamine. Interviews would have had to take place late in the evening and there was no private space on site where interviews could be conducted. All other services agreed to identify workers and pass on their email addresses so that I could contact them and arrange an interview. This was a simple process, and I interviewed 13 workers between 8 July, 2009 and 22 February, 2011. Interviews usually took place in a local café or the worker's office.

A range of workers from each type of service was interviewed, allowing for coverage of service type, organisational role, professional background, seniority and decision-making responsibility. The interviews focused on the services offered; the practices of treating methamphetamine; guiding philosophies, beliefs or models; perceptions of people who used methamphetamine characteristics and needs; and strategies employed to meet these perceived needs. In some cases, vignettes outlining possible service scenarios were also used in order to prompt service providers to describe their practice in more detail.

Vignettes were based upon themes that emerged from interviews with people who used methamphetamine. I had hoped that the use of vignettes would assist to elicit the step-by-step procedures involved in the practice of treating methamphetamine, in a way that did not threaten service providers' professional identity. I had initially planned to use the vignettes in all interviews, but in some cases there was not enough time (almost every service provider that I interviewed was pressed for time and only able to meet for a maximum of an hour). In other cases, I felt that questions of practice had been thoroughly covered to the point where the use of a vignette would have been tedious for both the interviewee and myself.



## **Interviewing people who use methamphetamine**

People who use methamphetamine were eligible for participation in this study if they were over 18 years old, and had been using methamphetamine at least once a week for the previous six months. These eligibility criteria ensured that the people I interviewed had reasonable experience of methamphetamine use. As stated above, I sought to interview both people in regular contact with health services and those with no contact with services. People who use methamphetamine were considered service users if they had accessed one of the harm reduction, treatment and other services taking part in the study in the 30 days prior to the interview. This meant that they could be interviewed about their recent experience of a health service. This group of participants were not considered to be service users if they had had no contact with health services in the six months prior to the interview.

Most of the participating services identified potential research subjects through their practice and provided them with my contact details. In one case, a flyer was placed in the service waiting area with my contact details so service users could contact me if they wished. In the case of two inpatient services, a staff member contacted me to let me know that there was a potential participant on site. We then arranged a time for the service user to meet with me (on site) so that I could tell them about the research and see if they were interested in taking part. In all cases, once I had met the person on site, they agreed to participate in the research and we did the interview immediately.

People who use methamphetamine were interviewed through only four of the seven services I approached. This may have been because several services were not accessed by people who were regularly using methamphetamine. Most service users were recruited through two of the services approached, and then one each from the remaining two services. In total, I interviewed 15 people who use methamphetamine who were also accessing harm reduction and/or treatment services between 12 October, 2009 and 2 March, 2011.

Initially I was apprehensive about my capacity to recruit people who use methamphetamine and did not access services; however, this task proved to be easier than I had expected for two reasons. First, a personal acquaintance living in the area in which the research was conducted knew people who used methamphetamine regularly and agreed to distribute my business card amongst his peer group. As a result, I was contacted by seven people and I interviewed all of them. Second, I was able to access eight people through a concurrently run epidemiological research project on methamphetamine use in Melbourne (Quinn, 2012). I purposively

recruited people by asking the researcher conducting this project to pass on my contact details to people using methamphetamine that lived in or near the area in which I was conducting my research. In total, 13 people using methamphetamine who had not used services in the past six months were interviewed between 11 July, 2009 and 2 November, 2011.

My aim was to interview people using methamphetamine ‘heavily’ in order to ensure participants were very familiar with the practices of methamphetamine use, including purchasing and (possibly) selling the drug, as well as the various ways it can be consumed. I also thought that people using the drug regularly would be more likely to have experienced effects such as financial stress, relationship and family problems, employment and health issues. Further, ‘heavy users’ are often the subject of research and I wanted to provide an alternative account of heavy users that was not based on their individual pathology or the amount of drug-related harm they experienced. For my purposes, ‘heavy use’ was defined as using methamphetamine more than once a week. I did, however, interview three people who used methamphetamine less often than this. This was because these participants thought of themselves as methamphetamine users and had used methamphetamine heavily in the past.

Interviews with people who used methamphetamine focused on the practice of use and its effects. Attention was given to age, gender and length of involvement with methamphetamine use in order to explore a range of experiences. Interviews covered family background; education/employment histories; drug use history; current methamphetamine (and other drug) use; rationale for, and elements influencing, use (including attitudes, beliefs, practices, and social and physical environments); previous health service encounters; and barriers and incentives to accessing health services. Participants were reimbursed \$40 cash (approximately US\$37.50 in 2014) or the equivalent in the form of a voucher for their time and out-of-pocket expenses in accordance with accepted practice in Australia (Fry & Dwyer, 2001) and internationally (Anderson & DuBois, 2007).

### **Field notes and interview spaces**

I took notes after each in-depth interview. A material—semiotic approach to research requires attention to spaces and objects. Law (2002) argues that ‘*spaces are made with objects*’ (p. 96, emphasis in original), so describing objects was integral to establishing the space within which each interview took place. These spaces included an inpatient detox centre, a beer garden, the lounge room of a student group house, various cafés and staff rooms. After each interview I made notes about the interview context, sometimes drawing a

diagram of the space where the interview had taken place. In my notes I described how I felt, how I perceived the interviewee reacted to me and to the content of the interview, our surroundings and other people I interacted with in the context of the interview. These field notes were invaluable in helping me to take into account the ‘things’ that acted to produce accounts, as well as those that shape and produce drug use and drug harm reduction/treatment practices.

### **The production of accounts**

Approaching research from a material—semiotic standpoint entails assuming that research practice is constitutive of the objects of research (rather than reflective of them) and is a political exercise in that it makes some objects present and others absent or othered. Therefore, in defining the participants that are eligible for interview, the researcher materialises particular objects of research. My objects of research were people who used methamphetamine and people who treated methamphetamine use. This was because I expected that these two groups of people would be able to relate experiences and ideas about both consumption and harm reduction/treatment. Of course, in interviewing these particular actors, I would also enact the object ‘methamphetamine’ itself. In materialising these objects of research, and employing particular methods to inscribe them, specific accounts of methamphetamine-related practice were produced. In this section I discuss some of the ways in which these were constituted.

The main tool with which information about methamphetamine-related practice was collected was the in-depth interview. In-depth interviews are a mainstay of qualitative research. As a research tool they are employed to elicit ‘thick’ descriptions of the subject’s experience of their social world (Minichiello, Aroni, Timewell, & Alexander, 1995). However, they may also make particular assumptions about the subject — for example, that the subject is the centre of experience, unitary and autonomous (Martin & Stenner, 2004). I wished to avoid using interviews in this way and instead sought to use interviews as a way of documenting practices. I was interested in how these practices enacted methamphetamine and methamphetamine using-subjects. By focusing on practice, interviews were not used in order to make assumptions about the individuals who participated in this research, but instead as lay ethnographer accounts. In their research on diabetes, Mol and Law state:

The quotes in this article are not supposed to tell the reader about the specificities of the *people* uttering them. Instead they are intended to inform us about the *practices* of dealing with diabetes — practices that are so spread out that they are hard to study

ethnographically for a limited number of researchers who have only limited time, and would prefer not to intrude for long periods into other people's lives by spending days and days with them. So we take professionals as well as people with diabetes as (*lay*) *ethnographers* in their own right, taking it upon ourselves to select, translate, combine and contrast their stories (Mol & Law, 2004, p. 59, emphases in original).

These accounts were also used as a method of following the actors (Latour, 2005), literally as well as figuratively. In a literal sense, interviewing people using methamphetamine led me into their houses, to their treatment providers and to the places they socialised, such as a local café or pub. Likewise, interviews with service providers led me into their services. This gave me access to the spaces in which methamphetamine was consumed and treated. In a figurative sense, this meant allowing the interview to be led in perhaps unexpected directions. As the researcher I set the parameters of the interview and the research topic and determined the relevance of what was discussed during the interview. However, taking the lead from participants meant that although there was a set list of themes, I was open to the interviewee raising any methamphetamine-related topic. For example, questions on gender and the practice of methamphetamine were not included in this set list yet, on multiple occasions, interviewees led the interview to discussions on this issue.

In addition to the practice of the in-depth interview itself, other subjects, objects, spaces, inscription devices and hinterlands acted to produce particular accounts of methamphetamine use and service provision. In order to demonstrate some of the ways in which particular accounts were constituted I describe the interviews that took place at two inpatient services. The physical surroundings of these services were very different from those of the other interviews I conducted; they were highly regulated clinical environments. Some of the behavioural restrictions to which clients were subject included being unable to consume sugar and (for the interviewee) being unable to leave the building. Before my first interview at one of the inpatient sites, I was waiting in the 'quiet room' while my interviewee was notified that I had arrived. Looking around the room I became aware of at least five 'do not' notices, including 'Do not smoke', 'Do not leave this door open' and 'Do not touch this stereo'. These small signs acted to emphasise what was a highly regulated environment. Without them, the room would have been a simply furnished, quiet and warm room. With them, one was reminded at all times of the need to adhere to the rules. Thus, the 'quiet room' was a space for quiet but not a space in which one could easily relax.

All but two of the people I interviewed in this particular setting gave evidence that they experienced significant social and economic disadvantage. They were recipients of unemployment payments or pensions, described low levels of education and substantial degrees of state intervention in their lives (such as contact with the legal system, child protection system and so on). I have not experienced these forms of disadvantage and upon meeting these inpatient clients I was keenly aware that various ‘things’ (such as my black-rimmed glasses and haircut, my notebook and pen, and the way I spoke) made it clear that significant social and economic differences separated us. These objects acted to constitute me as a privileged individual and perhaps a figure of expertise. It is possible that they shaped the interaction between myself and the interviewee. Certainly, I was positioned by a number of the interviewees at the in-patient services as a case worker or a social worker/psychologist. This was evidenced by the following statement from Ross, a 38-year-old man, at the completion of his interview:

I know that the more I do it [talk about methamphetamine use], the better, the easier it’s going to feel for me, like the better I’ll feel about meself because I’m releasing all this stuff and I, I can just feel it already, it feels like a little bit has been lifted off my shoulders just from sitting here talking, you know.

This statement appeared to be intended to reassure me that the interview itself was part of Ross’s therapeutic process. At the completion of another interview that took place in an inpatient service, the participant seemed to think I was a case worker and requested that I contact an AOD counsellor in his local town and make an appointment for him.

It was frustrating being perceived as a worker of some sort rather than as a researcher, as this might have generated particular accounts of methamphetamine use, and of the needs relating to this activity, that were shaped by treatment discourse. This could have led inpatient participants to position themselves as someone who was sick from drug use and needed treatment to stop taking drugs. In addition to the way in which my position was (mis)understood by clients at the inpatient services, the space in which they were interviewed was also constitutive of accounts. These participants were being interviewed during a course of treatment in a highly regulated treatment facility. Their status as drug treatment clients was reinforced even in areas designated for quiet time. It is not surprising, then, that in order to understand and explain their drug use, they drew upon the meanings available within the AOD hinterland. I am not seeking here to negate these accounts, or to downplay the experiences of drug use and drug treatment related during the interview. Rather, I wish to

draw attention to the multiple possibilities of interview practice. Had I appeared as other than a ‘worker’, or had the interview taken place in different spaces, it is possible an alternative account of methamphetamine use and treatment would have been produced, perhaps one that subverted treatment discourse.

In describing my experience of interviewing inpatient residents here, I aim to demonstrate that interviews are a constitutive practice. They are spatially and temporally located, and enacted through the connections and relationships formed between myriad subjects and objects. They can also be conceived as an inscription device. This is because they are a tool with which one makes data, transforming a phenomenon (for instance, the act of consuming drugs) into data. The accounts within this text are, in this way, contingent, enacted through the connections and interaction of a range of entities, not least myself and the participant. However, despite the assertion that these accounts could have been different, they are always constituted within, and in relation to, particular hinterlands and conditions of possibility. Because of this, while there are multiple possibilities, these are shaped by the current episteme. In the case of this research, the commonality is the restrictive ways in which we can think about drug use and drug users.

### **Interpreting accounts**

In conducting interviews and taking field notes I collected a large amount of data. As a first step in managing these data, interview transcripts and field notes were entered into the data management software program NVivo8™. This allowed large amounts of data to be stored and accessed easily. I then undertook coding: the identification of patterns through repetition and amplification (Law, 2004, p. 111). Once patterns were distinguished, appropriate theoretical tools with which these patterns might be analysed were employed. For example, when reading through scientific texts concerning methamphetamine I was struck by what appeared to be glaring contradictions within and between texts. This led me to the body of knowledge that addressed the contingent nature of science – STS – and specifically Latour and Woolgar’s early work. I therefore used STS theoretical concepts to illuminate these data. The theoretical concepts I used underwent a process of exchange and adaption as data were collected and coded. Subsequently the patterns that were established in the early stages of the research developed into the themes of my research. These included the way in which methamphetamine is enacted in authoritative discourse and the co-existing subjectivities of agentive and non-agentive methamphetamine users materialised in treatment practices.

When presenting accounts, researchers necessarily make decisions about which statements to amplify and which to leave out. I collected a large body of data on methamphetamine, consumption practices, harm reduction/treatment practices, purchasing and selling, gender, parenthood and so on. Ordering these data to produce a research text was a necessary but limiting process. In selecting some themes to amplify I have necessarily left many out. My ‘controversial agency’ as author of this research account (Latour, 2005, p. 138) determines what is made present, what is made ‘manifestly absent’ and what is ‘Othered’ (Law, 2004, p. 161). To acknowledge one is effectively employing a method assemblage is a commitment to make the political nature of realities overt and to the enactment of realities that might be ‘systematically Othered’ (Law, 2004, p. 132). Thus, in undertaking this research, I seek to create a text that is an ethical account of methamphetamine-related practices, without further pathologising and marginalising people who use methamphetamine.

### **Practicalities: Ethical considerations**

I was mindful of several practical ethical considerations during the course of this research.

#### **Privacy and confidentiality**

People who use methamphetamine risk prosecution as well as social exclusion. For these reasons, interviews with methamphetamine users were confidential, and the majority took place in private spaces within harm reduction/treatment or other health services or within the interviewee’s house. Twenty-seven interviews took place in public spaces such as cafés or parks. In these cases, every attempt was made to ensure privacy. If the interviewee felt his or her privacy was compromised at any time, we stopped the interview and moved to a more private space before resuming. Interviews conducted with service providers were also confidential as they were asked to discuss issues of service philosophy and practice that could have been considered contentious within the workplace. However, for the most part, the majority of service providers were at ease being interviewed in a public environment such as a café. All of the services involved in this research remain anonymous and I have not named the suburb in Melbourne in which the majority of interviews took place. This ensures that any critique of service practice is not seen as specific to a particular service. It also ensures that service providers who were interviewed cannot be identified. All those who took part in the research were asked to choose a pseudonym and this was used to identify their data. All printed data were kept in a locked cabinet accessible only to me.

### **Informed consent**

A participant information sheet outlining the purposes of the research and the implications of participation was prepared in plain language (see Appendix B). Participants were given this sheet prior to the interview and oral or written consent was obtained after reading the plain language statement and before commencing the interview. At all stages of the research, participants were able to withdraw their consent to participate, however, none did so. As 13 participants were recruited through services at which they were undertaking drug treatment, the participant information sheet stated that taking part in the research was not a requirement for access to these services and that declining to take part in the research would have no impact on service access.

### **Interviewee distress**

In case people became distressed during the interviews, I established a set of procedures including the provision of harm reduction information and the contact details of counselling or other drug services if required. These procedures have been implemented in previous research involving people who use drugs (Neale, Allen, & Coombes, 2005). None of my interviewees became noticeably distressed as a result of the interview despite, at times, relating distressing events in their lives. On a few occasions during or after an interview I was asked for my 'professional' opinion on a particular drug treatment or drug. In these cases I usually gave participants the contact details of a 24-hour AOD counselling and advice service.

### **Conclusion**

Methamphetamine and people who use this drug are currently understood in particular ways. Most biomedical, public health and a body of sociological literature addresses methamphetamine as a 'matter of fact', reifying it as a potent and dangerous object. People who use methamphetamine are enacted as highly transgressive, addicted or at risk of addiction and always in need of intervention. These fixed and pejorative identities contribute to the marginalisation of these individuals. Further, this literature explains the social, economic and health problems they may experience in terms of their purported relationship to the consumption of methamphetamine. This effectively locates responsibility for these problems within the individual drug user and negates the requirement of a collective response to any disadvantage they may experience.



My aim with this research was to investigate the ontological politics of methamphetamine. That is, to show how dominant discourses and practices constitute methamphetamine and methamphetamine users and how, at the same time, these are resisted and subverted. I achieve this by examining authoritative texts and tracing the ways in which these constitute methamphetamine and methamphetamine-using subjects. Contradictions, slippages and the inscription of materiality in these texts are foregrounded. I also address methamphetamine-related practices in a way that acknowledges the multiplicity and complexity of the world. I undertook individual interviews, treating these as lay ethnographer accounts, constituted through interactions between the interviewees and myself, as well as myriad spatial and temporal aspects. Analysing these accounts, I consider methamphetamine and methamphetamine-using subjects as located within assemblages of objects, subjects, spaces, networks and institutions. I show what these assemblages enact, spotlighting the multiple subjects and objects constituted through localised networks of methamphetamine-related practice. In describing the effects of hegemonic understandings of methamphetamine on these materialisations, the political and contested nature of realities is illuminated.

A post-structuralist and STS sensibility assumes that research itself enacts realities, and the realities it produces are the result of, among other things, the patterns and themes that the researcher has chosen to amplify. As such, this research is only a fragmented and partial rendering of methamphetamine-related practice. It makes some things present, and in doing so, makes others absent. In noting what is present and potentially made absent or othered, however, I aim to remain cognisant of the political implications of realities and produce a text that does not marginalise or pathologise people who use methamphetamine.

The following chapters are ordered to give consideration first to the object 'methamphetamine' and then to the practices that enact it. In the first of my empirical chapters, Chapter Four, I describe the way methamphetamine is enacted in scientific practice and authoritative texts. Chapter Five describes the enactment of methamphetamine-using subjects in policy and treatment practice. Chapter Six describes methamphetamine-using practices and how they materialise particular subjects and methamphetamine. Chapter Seven describes harm reduction and treatment practices and their materialisations.

## Chapter 4: Methamphetamine ‘facts’: The production of a ‘destructive’ drug in scientific texts

### Introduction

This chapter addresses the first of my research questions: how are methamphetamine and methamphetamine consumers constituted in scientific, policy, treatment and media discourse? I analyse the ways in which methamphetamine, its use and those who consume it are discursively produced in scientific research.<sup>6</sup> I do this because scientific discourse plays a key role in the enactment of ‘methamphetamine’, and shapes how the drug is understood in policy and practice.<sup>7</sup> In this chapter, I argue that scientific texts enact methamphetamine as a specifically destructive drug and constitute users of this drug as uniquely problematic.

Although I focus on Australian research in my discussion, some of the methods, assumptions and analytical trends that I identify can also be found in international research on methamphetamine. In particular, neurological research on AOD addiction is almost exclusively driven by researchers from the US and so, when addressing this issue, I refer to US research.

In making my argument I draw on several insights from STS. These were discussed at length in the previous chapter but here I briefly revisit them in order to make explicit the theoretical underpinnings of the analysis presented this chapter. First, STS conceptualises science as a form of cultural practice no different from other cultural endeavours such as art and religion (Latour, 2004; Latour & Woolgar, 1986). Thus the outcomes of scientific practice — ‘facts’ — are worthy of interrogation and should not be considered a ‘sphere of incontestable knowledge’ (Jasanoff, 2011, p. 11). The facts produced by scientific practices do not merely describe an anterior reality but are constructed and contingent. They involve ‘slow, practical craftwork’ (Latour & Woolgar, 1986, p. 236) and supportive technical apparatus. These act as ‘inscription devices’, which Latour and Woolgar (1986) defined as:

any item of apparatus or particular configuration of such items which can transform a material substance into a figure or a diagram which is directly useable. (p. 51)

In order for a fact to materialise, all evidence of its inscription process must disappear, and a shift must occur ‘whereby an argument ha[s] been transformed from an issue of hotly contested discussion into a well-known and noncontentious fact’ (Latour & Woolgar, 1986,

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<sup>6</sup> See (Dwyer & Moore, 2013) for a related analysis of the production of methamphetamine psychosis in Australian public discourse and consumer accounts.

<sup>7</sup> For example, the Australian national policy on drugs makes a ‘strong commitment to ... evidence- informed practice, innovation and evaluation’ (Ministerial Council on Drug Strategy, 2011).

p. 76). Such work emphasises (1) the made-ness of facts as the material world is transformed into a stable object of scientific study; and (2) the contingency of facts — alternative ways of knowing the material world are always possible using different inscription devices.

The second insight from STS focuses on the performative dimension of scientific practice (Latour, 1999; Law, 2004; Mol, 1999), in which reality is conceived as fluid and multiple. This insight extends the idea that science is the construction of facts, objects and a singular and stable reality, by positing that scientific practices continually enact and re-enact *multiple* realities. Whereas the concept of construction implies that ‘an object has been constructed’ (Law, 2004, p. 56) and is therefore closed or completed — it has ‘become’ — ‘enactment’ or ‘practice’ (Mol, 1999, p. 77) emphasises the ongoing, never completed, practice of inscription. Realities, thus, depend upon ‘continued crafting’ (Law, 2004, p. 56). Further, there is no essential, singular object or reality to be discovered beneath these inscriptions; reality is a multiple phenomenon. Law (2004) states:

If we attend to practice and to objects we may find that no objects are ever routinised into a reified solidity. We may find that there are no irrevocable objects bedded down in sedimented practices...And if things seem solid, prior, independent, definite and single then perhaps this is because they are being enacted, and re-enacted, and re-enacted, in practices. Practices that continue. And practices that are multiple. (p. 56)

A third insight from STS relates to the politics of realities. Law (2004, p. 27, 96) argues that specific facts emerge from hinterlands, which he defines as ‘network[s] of other statements, materials and practices’. Therefore, realities are not enacted arbitrarily but materialise in accordance with previously accepted truths and knowledge. Inscription devices — which Law (2004, p. 29) defines as ‘a set of arrangements for labelling, naming and counting’ — are a crucial component of hinterlands. Scientific knowledge is generated by a ‘single authorised set of inscription devices’ (Law, 2004, p. 32), obscuring the multiplicity of reality and enacting a singular and highly authoritative version of the world.

The final insight from STS concerns the distinction between ‘matters of concern’ and ‘matters of fact’ (Latour, 2004, p. 231). Responding to critiques of his earlier work on the social construction of scientific knowledge, Latour (2004) argues that scholars have misunderstood him to be suggesting that all facts are fabricated and lacking any material basis:

The question was never to get *away* from facts but *closer* to them, not fighting empiricism but, on the contrary, renewing empiricism. (p. 231, emphasis in original)

Here Latour calls for a renewed empiricism, one that would attend to the complexity of reality, scrutinising facts and expanding upon their materiality. As it stands, Latour argues that facts are related to the material world but ‘are only very partial...very polemical, very political renderings of matters of concern’ (Latour, 2004, p. 232). By critiquing facts and expanding upon their relationship to the material world, Latour seeks to turn matters of fact back into collective matters of concern. This means finding ways, such as a renewed form of empiricism, to describe matters of concern in the world without reducing them to incontestable matters of fact.

I draw on these insights to analyse the enactment of methamphetamine in scientific texts, focusing mainly on Australian research. This does not mean that I see the body of evidence on methamphetamine as fabricated or as having no material basis. Rather, my interest is in how specific realities of methamphetamine and its use come to be enacted as scientific facts by particular inscription devices and hinterlands, and the political effects of these enactments for people who consume methamphetamine.

### **Enacting methamphetamine in Australian scientific literature**

Methamphetamine emerged as a new problem in Australia during the late 1990s and early 2000s with police seizure data suggesting that this form of amphetamine had supplanted amphetamine sulphate as the dominant Australian type (Australian Crime Commission, 2001). The identification of methamphetamine as an emerging problem in Australia spawned numerous studies that sought to establish its prevalence, quantify the types and levels of harm relating to its use, and identify and evaluate the available treatment options (see Appendix A). Although identified as new in the Australian context, by 2002 methamphetamine was already well established as a drug of scientific interest internationally. The scientific texts existing at that time identify methamphetamine use as widespread in the US, especially in Hawaii (Freese, Obert, Dickow, Cohen, & Lord, 2000; Wolkoff, 1997) and the mid-Western states (Rawson et al., 2002), as well as in Japan (Suwaki, 1997; Tsuchihashi et al., 1997), China, Indonesia, Thailand and the Philippines (Farrell, Marsden, Ali & Ling, 2002). In these texts, methamphetamine use is repeatedly described as an ‘epidemic’ (Farrell et al., 2002, p. 771; Freese et al., 2000, p. 177; Rawson et al., 2002, p. 145), or as ‘extensively abused’ (Tsuchihashi et al., 1997, p. 1796). Other international texts state that methamphetamine is a more potent form of amphetamine that is associated with ‘structural abnormalities’ in the

brain (Thompson et al., 2004, p. 6028), neurocognitive ‘impairment’ (Kalechstein, Newton, & Green, 2003, p. 215) and poor physical health (Greenwell & Brecht, 2003). This body of existing scientific knowledge produced methamphetamine in very specific ways, and provided an established set of facts about methamphetamine — a hinterland (Law, 2004) — that Australian researchers referenced and extended in their work.

In analysing scientific texts on methamphetamine, I focus on four claims that help to produce methamphetamine as a new and destructive drug: that (1) methamphetamine is more potent than other amphetamines, (2) methamphetamine is associated with dependence, (3) methamphetamine is harmful, and (4) crystalline methamphetamine (ice) is more harmful than other forms of methamphetamine. I have selected these claims for analysis because they are made repeatedly in the scientific literature. Furthermore, because these claims are ubiquitous in scientific discourse, they actively shape understandings of methamphetamine in policy, practice and public discourses. In order to attend to these claims, I was guided by the work of Latour & Woolgar (1986) and their scrutiny of scientific practice. Scientific articles were selected on the basis that they contributed significantly to a particular claim. These texts were then carefully examined for contradictions in the cited evidence, inscriptions of methamphetamine’s materiality and instances of ‘literary inscription’ (Latour & Woolgar, 1986, p. 76). In some cases I carried out additional searches. For instance, in some articles, I traced a path of inscription back through earlier publications cited as evidence for various claims about methamphetamine.

### **Methamphetamine is potent**

The first claim I investigate is that methamphetamine is a specifically potent drug. This claim is often made to justify the assessment of methamphetamine as uniquely ‘destructive’ (Topp et al. 2002a). Moreover, methamphetamine is delineated from amphetamine by asserting it is *more* potent. For example, Kaye and colleagues (2008) state:

Following a shift in the mid-1990s from the production and supply of amphetamine to the more potent methamphetamine, as well as increases in the availability and use of high purity crystalline methamphetamine, there has been a marked increase in methamphetamine-related problems (McKetin, 2007). (Kaye, Darke, Duflou, & McKetin, 2008, p. 1353)

The following statement is repeated in two separate articles concerning methamphetamine:

Compared with amphetamine, methamphetamine has proportionally greater central stimulatory effects than peripheral circulatory actions (Chesher, 1993), and is a more

potent form with stronger subjective effects. (Degenhardt & Topp, 2003, p. 17; Topp et al., 2002a, p. 342)

These statements assert the specificity of methamphetamine on the basis of its greater potency — it is a ‘hyper’ stimulant — stronger and more problematic. And yet the assertion that methamphetamine is ‘potent’ in these statements is tenuous at best. In the first statement from Kaye et al. (2008) the assertion that methamphetamine is more potent is verified by citing McKetin (2007); however, the cited text states that methamphetamine is a ‘more potent analogue’ of amphetamine *without* citation (McKetin, 2007, p. 24). In the second example both Degenhardt & Topp (2003) and Topp et al. (2002a) cite a chapter (Chesher, 1993) in a report funded and published by the Federal Government and the NSW Health Department (Burrows, Flaherty, & MacAvoy, 1993) to assert that methamphetamine has greater central stimulatory effects than amphetamines. Reading the chapter by Chesher (1993), one finds this claim is made without evidence or citation:

It [methamphetamine] has proportionally greater central stimulatory effects than peripheral circulatory actions. (pp. 11-12)

Chesher (1993) bypasses the step of literary inscription and asserts the potency of methamphetamine without the required act of citation. It is testament to the authority of scientific literature, as well as the reputation of methamphetamine itself, that these statements are left unchallenged, and yet repeatedly made in scientific journal articles.

As I shall show below, measuring a drug’s potency is a difficult task, typically involving neurological research with animals. While this area of research has not been a major research focus in Australia, in the US it is ‘a well-funded, state-sponsored specialty’ (Vrecko, 2010, p. 54). There is, for example, a significant body of work originating from the US comparing the potency of a range of stimulants (see, for example, Hall, Stanis, Marquez Avila, & Gulley, 2008; Sevak, Stoops, Hays, & Rush, 2009; Shoblock et al., 2003). In these experiments potency *per se* is not measured; rather, researchers study *effects* that might indicate potency. They then measure these effects and present the resulting data as evidence of potency. This requires that the scientists undertaking these experiments make decisions about how to conceptualise, and thus measure, the concept of potency. Typically, these experiments aim to assert that methamphetamine is more potent than other amphetamines, but the results are rarely unequivocal. For instance, Hall and colleagues (2008) conclude:

These results, in addition to studies with higher doses of these drugs (Shoblock et al. 2003; Segal and Kuczenski 1997), suggest that there are certain conditions where

METH [methamphetamine] is more potent than AMPH [amphetamine sulphate] at stimulating behaviour, but the common characterisation of METH as a more potent psychostimulant is not consistent with the available experimental evidence. (Hall et al., 2008, p. 478)

This statement recognises that methamphetamine is typically considered a more potent drug than other amphetamines. However, in noting that this characterisation is not borne out by the available research evidence, a definitive assessment of methamphetamine's potency over other forms of amphetamine is left open.

I now examine the article 'Neurochemical and behavioral differences between d-methamphetamine and d-amphetamine in rats' (Shoblock et al., 2003) because it provides an example of the work involved in establishing the difference between dextroamphetamine and methamphetamine. This research sought to delineate these two substances in two ways, through 'potency' and 'addictive potential' (p. 367). For the purposes of my argument, I address only the claim of potency. The researchers measured potency by comparing locomotor activity after injecting methamphetamine and dextroamphetamine into the brains of rats (Shoblock et al., 2003, p. 360) and assuming that greater locomotor activity is associated with higher potency. They measured locomotor activity by observing and recording the rats' movements within 'black, opaque cylindrical photocell activity cages (diameter 60 cm, three crossing beams)' (Shoblock et al., 2003, p. 361). If two light beams were interrupted in succession, this was recorded as one 'activity count' (Shoblock et al., 2003, p. 361). Thus the box, light beams and observation enabled rat activity to be translated into data. Using these data the researchers were able to make particular claims, and so the concept of potency becomes a stable object of study.

At the commencement of the article, the authors note the similar chemical structure and properties of methamphetamine and amphetamine:

METH and AMPH are both phenylethamines, METH being the N-methylated analogue of AMPH. Besides sharing a similar structure, METH and AMPH share several pharmacokinetic and pharmacodynamic properties. (Shoblock et al., 2003, p. 359)

Following this, the authors report that, in relation to amphetamine, 'it is commonly accepted that METH is more addictive and favoured by drug addicts' (Shoblock et al., 2003, p. 359). The authors provide no basis for this statement, demonstrating the pervasiveness of this

particular understanding of methamphetamine. Nonetheless, the purpose of the article is to differentiate between the two drugs and in order to demonstrate a need for their study, Shoblock and colleagues' explain that:

despite the repeated claims of METH being more addictive or preferred than AMPH, proven differences between METH and AMPH in addiction liability and in reward efficacy have evaded researchers. (Shoblock et al., 2003, pp. 359-360)

This statement acknowledges that while it is claimed that methamphetamine is more addictive and potent than amphetamine, researchers have not yet been able to prove this.

When the results of the research are presented by the authors in this text, it is apparent that they do not reflect the 'commonly accepted' properties of methamphetamine. According to the results, amphetamine produced greater locomotor activity in the rats than methamphetamine, leading the authors to conclude:

In contrast with the well accepted view, we conclude that METH is not a greater central psychomotor stimulant compared to AMPH, at least not in female rats. (Shoblock et al., 2003, p. 366)

At this point, the researchers discuss the origins of the assumption that methamphetamine is more potent than amphetamine. By referring to older texts, they conclude that previous research was flawed and cast doubt on the claim that methamphetamine is a more potent drug:

Examination of the literature finds no evidence in any behavioural paradigm that METH has greater central stimulatory effects compared to AMPH. (Shoblock et al., 2003, p. 367)

However, given the strong statements made at the commencement of the text about the potency of methamphetamine, it is difficult to understand why the researchers do not make more of this finding. It is notable that in the conclusion of the article and the abstract, this finding is not mentioned. Instead, in the conclusion the authors focus on the implications of their findings for methamphetamine addiction (p. 367).

This article is an example of the work involved in crafting 'facts' and of how materiality is inscribed to make claims about the world. In this case, the movement of rats was translated into data that inscribed methamphetamine in a specific way. However, the article also demonstrates the interplay between the scientific hinterland and more lay understandings. Shoblock and colleagues downplayed their finding that methamphetamine was less potent



than amphetamine. Perhaps this was because it did not fit with the way in which the hinterlands of the mass media and addiction research generally understand methamphetamine.

### **Methamphetamine and dependence**

The second major claim I examine concerns dependence. At approximately the same time as methamphetamine was increasingly being identified as an illicit stimulant of concern in Australia, several journal articles and technical reports defining amphetamine as a drug of dependence were published (see Topp & Darke, 1997; Topp & Mattick, 1997a; Topp & Mattick, 1997b; Topp, Mattick, & Lovibond, 1995). While much of the evidence regarding a dependence syndrome was established in relation to amphetamine, this evidence was readily applied to methamphetamine even as intensive efforts were underway to establish methamphetamine as different from amphetamine (Hall et al., 2008; Sevak et al., 2009; Shoblock et al., 2003). Consider, for example, the following statement (Topp et al., 2002b, p. 153):

Although historically the subject of much debate, the existence and destructive nature of a methamphetamine dependence syndrome, comparable to that long acknowledged to exist for alcohol and heroin, was recently documented (Topp & Darke, 1997; Topp et al., 1998; Topp & Mattick, 1997a, 1997b).

I draw attention to two aspects of this quotation. First, all of the articles and reports cited as documenting the existence of a ‘methamphetamine dependence syndrome’ deal specifically with ‘amphetamine’. This re-labelling of amphetamine as methamphetamine is widespread (McKetin, Kelly, & McLaren, 2006a, p. 199) and points to a tendency to distinguish methamphetamine and amphetamine in accounts emphasising the rise of a new, more potent and more harmful drug — methamphetamine — but to collapse them in other contexts and for specific strategic purposes (for example, when the evidence relating specifically to methamphetamine is limited or unavailable).

Second, it provides a glimpse into the production of the ‘fact’ of methamphetamine dependence, while at the same time reinforcing this ‘fact’. In the first part of the statement, the authors refer to the previous ‘debate’ regarding the existence of the ‘methamphetamine dependence syndrome’ (even though the cited evidence relates to amphetamine rather than methamphetamine). Having acknowledged this debate, the second part of the statement ignores it by treating the methamphetamine dependence syndrome as a ‘documented’ fact. This discursive move achieves its aim by ‘drawing attention to the (mere) processes of

literary inscription [in order to] make the fact possible' (Latour & Woolgar, 1986, p. 76). In other words, by the act of citation — referring to articles that 'recently' inscribed a methamphetamine dependence syndrome — this fact is (re)produced.

One reason for the controversy regarding the original amphetamine dependence syndrome was the apparent absence of physical withdrawal following prolonged amphetamine use. While earlier understandings of addiction included both physical and psychological dimensions (Room, 1985), particular significance had been attributed to the physical manifestations of addiction (Keane, 2002). In order for amphetamine to be enacted as a drug of addiction, the psychological components were emphasised while the physiological aspects were downplayed. Topp and Mattick (1997a) argued that defining amphetamine dependence in this way was the result of changing ideas concerning the nature of dependence. These changes, while retaining physical tolerance and withdrawal in the definition of dependence, attached:

greater importance to symptoms such as a compulsion to use, a narrowing of drug-using repertoire, rapid reinstatement of dependence after abstinence, and the high salience of drug use in the user's life. (Topp & Mattick, 1997a, p. 839)

Thus, the authors draw attention to the shift in the understanding of addiction, driven by changing opinions that enabled the inscription of amphetamine as a drug of dependence.

The shift towards emphasising the psychological aspects of dependence expanded the 'conditions of possibility' (Mol, 1999, p. 75) within which the fact of amphetamine dependence could be established. At the same time, previous facts, such as the dependence syndrome associated with cocaine use, were part of a hinterland that could support the concept of amphetamine dependence. In the following statement, Topp and Darke (1997) note the similarity between the cocaine and amphetamine dependence syndromes:

Compulsion to use is an integral component of the amphetamine dependence syndrome, which fits well with results that have identified preoccupation as the central feature of cocaine dependence. (p. 117)

With this statement, we see how the establishment of the amphetamine dependence syndrome is, in part, assisted by previous claims regarding cocaine dependence. The concepts of compulsion and preoccupation, already well established as integral to cocaine dependence, provide a ready-made framework for characterising amphetamine dependence.

In addition to redefining the central features of dependence, the identification of an amphetamine dependence syndrome required the adaptation of existing, or development of new, inscription devices for researching and classifying the *practices* of methamphetamine use. As Cho and Melega (2001) state:

The modelling of human METH abuse patterns is complicated by the lack of accurate data, especially when it is derived anecdotally from reports by drug abusers. (p. 29)

Inscription devices that translate methamphetamine ‘abuse patterns’ into stable objects of study include the Severity of Dependence Scale (SDS) (Gossop et al., 1995; Topp & Mattick, 1997a), the Severity of Amphetamine Dependence Questionnaire (Topp & Mattick, 1997b) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013). These devices allow the inscription of methamphetamine consumption as ‘non-dependent’, ‘dependent’ and ‘severely dependent’.

Translated into these categories, methamphetamine consumption becomes a stable object of investigation. This investigation involves diagnosing methamphetamine dependence and, therefore, the dependent/non-dependent binary is a central variable for analysis in research reports and journal articles that concern methamphetamine use (Glasner-Edwards et al., 2008a; Glasner-Edwards et al., 2008b; Gonzalez et al., 2009; Kalechstein et al., 2003; Kalechstein et al., 2000; Kinner & Degenhardt, 2008; McKetin et al., 2006a; McKetin et al., 2006b; Newton, De La Garza, Kalechstein, Tziortzis, & Jacobsen, 2009; Payer et al., 2008; Zweben et al., 2004). These reports and other methamphetamine-related research describe methamphetamine dependence by linking dependence to a range of other pathologies, such as trauma, depression, anxiety and psychosis, through measures of statistical significance. For instance, Messina and colleagues (2008) describe dependent methamphetamine users in terms of a comprehensive list of pathologies. The authors administer the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) to their sample of dependent methamphetamine users, which determines:

psychiatric conditions and symptoms in 16 domains (major depressive episode; dysthymia, suicidality, manic/hypomanic episode; panic disorder, agoraphobia, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, alcohol abuse and dependence, substance abuse/dependence, psychotic disorders, anorexia nervosa, bulimia nervosa, generalised anxiety disorder and antisocial personality disorder). (Messina et al., 2008, p. p 403)

This exhaustive list of pathologies is applied to already marginalised subjects and, invariably, serves to further compound the stigmatised identity of the ‘dependent methamphetamine user’.

This body of work reinforces both the pathologised identity of people who use methamphetamine and, through repetition, the concept of dependence itself. Yet, as the texts considered previously indicate, it is apparent that the definition of ‘addiction’ has subtly shifted. This demonstrates that methamphetamine addiction is not a pre-existing condition that has been revealed through science. Rather, scientific craftwork has enacted this condition by placing greater emphasis on the psychological aspects of addiction, and by referencing a hinterland involving the materiality of cocaine. It is this shift that has enabled the materiality of methamphetamine to be relocated within the addictive/non-addictive binary, and the subsequent pathologisation of methamphetamine ‘addicts’.<sup>8</sup>

### **Methamphetamine is harmful**

The third major claim in scientific texts that I examine concerns methamphetamine-related harm. In addition to establishing methamphetamine (and amphetamine before it) as a drug of dependence, the scientific literature has also attempted to establish the facts of methamphetamine-related harm. In Australia, multiple journal articles published since 2002 identify and measure a range of harms deemed to be associated with methamphetamine use (Darke et al., 2008; Degenhardt et al., 2008; Degenhardt & Topp, 2003; Kinner & Degenhardt, 2008; Rawstorne, Digiusto, Worth, & Zablotska, 2007). The concept of ‘harm’ is far from straightforward, however, as the following example demonstrates. Two articles that examine the harm associated with methamphetamine are ‘Major physical and psychological harms of methamphetamine use’ (Darke et al., 2008) and ‘The epidemiology of methamphetamine use and harm in Australia’ (Degenhardt et al., 2008). Although these articles originated from the same research centre and were published in the same volume and issue of the journal *Drug and Alcohol Review*, they make very different claims regarding the ‘harm’ related to methamphetamine use.

The first article, by Darke and colleagues (2008), outlines an extensive list of physical and psychopathological harms associated with methamphetamine use. Physical harms include toxicity, cardiovascular and cerebrovascular pathology, dependence and the transmission of

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<sup>8</sup> This is by no means specific to methamphetamine use. Eve Sedgwick (1992) and Helen Keane (2002) have comprehensively documented the widespread desire to understand substance use and a range of other behaviours as addictive.

blood-borne viruses.<sup>9</sup> Psychopathological harms include psychosis, depression, suicide and anxiety, violent behaviours and neurotoxicity. Darke and colleagues (2008) conclude by stating that:

this is a drug class that causes serious heart disease, has serious dependence liability and high rates of suicidal behaviours. The current public image of methamphetamine does not adequately portray the extensive, and in many cases insidious, harm it causes. (p. 259)

In this quotation, methamphetamine is constituted as a destructive and dangerous drug. This is a drug that causes ‘serious’ and ‘specific’ harms (Darke et al., 2008, p. 254). The use of the term ‘insidious’ implies that there is malicious intent involved in methamphetamine harms, attributing a treacherous agency to the substance itself. The concluding sentence warns that the effects of methamphetamine are not taken seriously by the public and that as a consequence methamphetamine has a more benign reputation than it deserves.

The second article, by Degenhardt and colleagues (2008), also reporting on the harms of methamphetamine use, presents a very different set of facts. In the article’s introduction, the authors refer to the public perception of methamphetamine and suggest that ‘unbalanced reporting’ (Degenhardt et al., 2008, p. 244) has contributed to increased concern about the nature and scale of methamphetamine use and harm. In other words, rather than having an undeservedly benign reputation, the authors of this article suggest quite the opposite; that the effects of methamphetamine are *not* as destructive as they are portrayed in the media.

Degenhardt and colleagues’ article focuses on the available types of methamphetamine and their use among the general population before presenting data on harm. One of their conclusions (Degenhardt et al., 2008) is that:

other indicators of meth/amphetamine-related harm did not show the dramatic increases that might have been expected given recent media attention, with indicators stabilising over recent years. (p. 250)

While the authors of this article readily acknowledge that there are issues of concern regarding methamphetamine, such as the availability of ‘stronger forms’, they offer the following conclusion about the effects of methamphetamine use among the Australian population (Degenhardt et al., 2008):

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<sup>9</sup> Note that despite the extensive earlier work on the importance of the psychological component in methamphetamine dependence (by colleagues in the same research centre), ‘dependence’ is listed as a ‘physical’ harm.

Concerns about harms related to methamphetamine, while deserved, must be placed within the context of harm related to other illicit drugs, as well as population level use. (p. 250)

This conclusion regarding methamphetamine-related harm is markedly different from that of Darke and colleagues (2008). Rather than understanding methamphetamine as responsible for extensive and insidious harms, Degenhardt and colleagues suggest that such harms should be kept in perspective.

How should we understand these multiple enactments of methamphetamine and harm? They illustrate my argument that scientific facts are inherently political forms of craftwork. For example, they involve decisions about data, methodological and analytical techniques, and interpretation. Although Darke and colleagues (2008) produce methamphetamine as an underestimated drug that causes extensive and insidious harms, Degenhardt and colleagues (2008) produce methamphetamine as a drug whose harmful effects are overestimated. Given the widespread view that methamphetamine is a potent, highly addictive and harmful drug, it seems no coincidence that Darke et al. (2008) has a much higher citation count in Google Scholar (223 citations) than Degenhardt et al. (2008) (69 citations) (Google Scholar search conducted on 8 August 2014). Darke et al.'s (2008) higher citation rate perpetrates the perception that the article itself is a more authoritative text on methamphetamine. It also indicates the findings of this article are more strongly broadcast.

### **Ice is more harmful than other forms of methamphetamine**

The final major claim I discuss is that ice is more harmful than other forms of methamphetamine. As I have argued above, methamphetamine is enacted within scientific texts as different from amphetamine in that it is more potent and addictive. Yet methamphetamine itself takes multiple forms, and scientific literature elaborates on the specificity of each of these forms. Four forms of illicitly manufactured methamphetamine are typically described: pills, base, powder and crystalline methamphetamine. Of these four forms, crystalline methamphetamine (ice) is considered purer, and thus more potent, than other forms of methamphetamine (Degenhardt & Topp, 2003; Fairbairn et al., 2008; Leonard, Dowsett, Slavin, Mitchell, & Pitts, 2008; McKetin et al., 2006a; Topp et al., 2002a). Further, in ascribing a greater potency to ice, it is claimed to have a greater capacity to cause harm (Cho, 1990; Fairbairn et al., 2007; Fairbairn et al., 2008; Kinner & Degenhardt, 2008; McKetin et al., 2006a; Topp et al., 2002a).

A key Australian article investigating the relationship between crystalline methamphetamine and one form of harm – dependence – is that authored by McKetin et al. (2006a). The authors justify their research by citing an earlier US study (Cho, 1990):

Cho (1990) attributed the addictive nature of crystalline methamphetamine to its high purity, and also to the fact that it can be smoked or ‘chased’, which causes an intense drug effect similar to intravenous administration. Despite this view, there has been no empirical investigation of whether crystalline methamphetamine users are more likely to report symptoms of dependence than people who use other forms of methamphetamine. (McKetin et al., 2006a, p. 199)

However, a close examination of Cho’s text reveals that, although he describes crystalline methamphetamine’s dangers and refers to ‘compulsive abusers’ (p. 634), at no point does he state that it is an addictive drug or refer to its addictive nature. Cho’s (1990) main point is that the ice problem is not new. He claims that it is ‘a slightly different form of drug abuse problem that has been around for decades, if not centuries’ (p. 634). He points out that the form this stimulant takes, and the way in which it is consumed, may lead to a range of problems but addiction is not mentioned. McKetin and colleagues (2006), however, in a subtle reframing of Cho’s comments, present the addictive nature of crystalline methamphetamine as an established fact. Confusingly, they then state there has been no empirical investigation of this ‘view’ and this serves as a justification for the research that they report. This particular interpretation of Cho’s commentary on ice further inscribes this drug as addictive and possessing destructive properties.

Further examination of the text produced by McKetin and colleagues reveals some of the ways in which ‘facts’ are produced through the inscription of drug use practices. On the basis of their research, McKetin et al. (2006) argue that:

crystalline methamphetamine users are more likely to be dependent on methamphetamine than their counterparts who use other forms of the drug. (p. 203)

In order for the researchers to reach this conclusion, it is first necessary for crystalline methamphetamine use to become a stable object of study. This was accomplished by creating two groups of research participants: those who used crystalline methamphetamine and those who did not. These two groups could then be compared and differences described in order for conclusions to be drawn about the nature of crystalline methamphetamine. Participants were categorised as ‘crystalline methamphetamine users’ if they had used this form of methamphetamine in the previous 12 months. In this group, 63% of people seemed to be

regular and even ‘heavy’ users of the drug, using crystalline methamphetamine in the month prior to the research interview, for a median of 5 days (McKetin et al., 2006a, p. 200). Conversely, this also means that it is possible that the remaining 37% of people in this group may have used crystalline methamphetamine only *once* in the previous 12 months. These participants, despite using crystalline methamphetamine very infrequently, are still categorised as crystalline methamphetamine users. Further, as the use of other forms of methamphetamine such as powder and/or base is disregarded in the analysis, it is also possible that members of the crystalline methamphetamine-using group may have used greater amounts of powder methamphetamine and/or base than crystalline methamphetamine. The authors note this issue and state that:

A further consideration is that most crystalline methamphetamine users also took other forms of the drug (i.e. so-called ‘base’ methamphetamine and powder methamphetamine, or ‘speed’), and were not exclusively crystalline methamphetamine users. (McKetin et al., 2006a, p. 203)

This acknowledgement does not, however, lead the authors to be more careful or nuanced in their conclusions concerning crystalline methamphetamine users.

Close examination of the processes through which people are classified as crystalline methamphetamine users shows the choices and work involved in translating crystalline-methamphetamine-using practices into an object of scientific study. I argue that in the process of translation from consumption to research object, McKetin and colleagues (2006a) simplify crystalline methamphetamine use to the point where it becomes almost meaningless.

Nonetheless, the authors make several claims about people who use ice. Not only do they find that crystalline methamphetamine users are more prone to dependence, they conclude that, as a result, members of this population are ‘hard to treat’ (McKetin et al., 2006, p. 203). They further argue that increased levels of dependence will be ‘likely to contribute to the complex nature of psychopathology encountered when treating crystalline methamphetamine users’ (p. 203). Thus, despite the loose eligibility criteria, the authors inscribe crystalline methamphetamine users generally as prone to addiction and as complicated and difficult people to treat. Given the problematic categorisation of participants in the research these conclusions seem to offer little insight into the nature of crystalline methamphetamine or the people who use it, but contribute instead to the enactment of ice users as a specifically pathological and difficult group of drug users.



Topp and colleagues (2002a) also address the use of ice in Australia and make claims regarding its harms. This text draws on data collected via the Illicit Drug Reporting System (IDRS)<sup>10</sup> in order to assess the impact of crystalline methamphetamine. Key informants (KIs) are a key data source for the IDRS; they are defined as those having professional ‘contact with a minimum of 10 different drug users and/or weekly contact with drug users in the 6 months preceding the interview’ (Topp et al., 2002a, p. 343). In this particular article, the interviewed KIs (who are quoted extensively) included ‘general health workers, treatment workers, law enforcement officers, outreach workers and drug users group representatives’ (Topp et al., 2002a, p. 343). They report the following finding:

All KIs who commented on side effects agreed that those methamphetamine users accessing the more potent forms tended to experience greater psychological and physical damage related to their use. These users were consistently described as more chaotic, more paranoid, more aggressive, more agitated, more damaged, harder to engage, more unkempt, more ‘hardcore’, ‘messier’ and generally much harder to deal with than users of methamphetamine powder. It was also agreed unanimously that the psychological and physical health declines among users of the potent forms of methamphetamine were far more rapid than among users of methamphetamine powder (speed). (Topp et al., 2002a, p. 346)

While the opinions of workers in the AOD field are undoubtedly important, strong and unqualified claims are made here about the putative effects of crystalline methamphetamine. For example, what is meant by the use of pejorative adjectives such as ‘chaotic’, ‘more damaged’, ‘messier’ and ‘hardcore’ to describe people who use crystalline methamphetamine? These terms have no technical meaning or application in the AOD field and, in this instance, serve only to enact the ice user as a subject to be feared. It is difficult to understand why the authors have included such subjective descriptions, which serve only to materialise a frightening subject — that of the ice user. Later in the article, Topp and colleagues offer a caveat of sorts with the statement:

although key informant reports provide a sensitive measure of emerging drug trends, they are also necessarily anecdotal and subjective. (Topp et al., 2002a, pp. 346-347)

Nonetheless, the opinions of the workers have been inscribed and so act to construct an understanding of crystalline methamphetamine as a dangerous drug, and crystalline methamphetamine users as an unmanageable population of service users.

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<sup>10</sup> See Dwyer and Moore (2010) for a critique of the IDRS methodology.

The legitimacy given to KI opinions by literary inscription is demonstrated by their repetition in other scientific texts. In a later article, Degenhardt and Topp (2003) argue that crystalline methamphetamine users would be likely to report similar or higher rates of side effects than users of powdered methamphetamine. To bolster their argument, they cite the publication discussed above (in which they are the first and second authors) and state that:

This [finding] would be consistent with findings of the IDRS, whose key informants (persons with regular, recent contact with drug users) noted that compared with powder methamphetamine users, users of crystal meth were more likely to develop problems more quickly (Topp et al, 2002). (Degenhardt & Topp, 2003, p. 23)

Thus, through self-citation, inscription and repetition, the varied opinions of a disparate group of people, the IDRS key informants, some of whom may have had little sustained contact with methamphetamine users and perhaps developed adversarial relationships with them (such as police), become scientific ‘fact’. These claims are derogatory in nature and enact highly marginalised subjects, who are represented as more problematic than other drug users. In this sense, the authority granted to these statements through publication is particularly concerning.

## **Conclusion**

The substance ‘methamphetamine’ has been constituted in scientific texts as a hyper-stimulant — dependence-producing and harmful, with crystalline methamphetamine inscribed as a specifically potent and destructive form of the drug. My intention in exploring these claims has not been to reveal the truth about the nature and effects of this drug; rather, I have sought to explore the scientific practices through which methamphetamine is transformed from a matter of concern into a matter of fact (Latour, 2004). In doing so, I have traced some of the work involved in establishing these claims as scientific facts. I have also sought to underline the contingency of facts, as contradictory statements come to light and rhetoric is employed to support various claims and beliefs about the drug. Through careful scrutiny of the scientific literature, it is possible to make visible the contradictions and political choices being made in the haste to generate knowledge about this drug. While science claims to document an anterior reality, it is evident that the materiality of methamphetamine has been inscribed to reflect a dominant hinterland of understandings concerning illicit substances. Because of the existing discourses, practices, substances and institutions that constitute the field of illicit drug use, it is difficult for science to make methamphetamine otherwise. If dependence is redefined to include psychological aspects,

then methamphetamine can be understood as a drug of dependence. If methamphetamine use is inscribed according to the dependence/non-dependence binary, the diversity of patterns of use and experiences are ignored. Only the practices of methamphetamine consumption that lead to dependence can be described. Indeed, dependence itself can be described and understood through its linkages to a network of pathologies. Invariably, the state of dependence is characterised by increased pathology as is consumption of allegedly more potent forms of methamphetamine — specifically ice. Thus, these ways of studying methamphetamine enact those who use the drug in pathologised and pejorative ways, and reify the drug itself as a potent substance that results in insidious and specific harms.

The ‘facts’ of methamphetamine contribute to the evidence base upon which methamphetamine policy and practice draws. As Fraser and Moore (2011) have argued, this is not a simple process; these documents in turn problematise methamphetamine and, in the case of policy at least, reproduce it as simultaneously a known and dangerous drug and poorly understood and documented. Additionally, the facts of methamphetamine contribute to the wider hinterland of drugs, and the four claims examined in this chapter are readily found in texts and resources concerning methamphetamine as well as in public discourse. Sometimes these claims are referenced explicitly, such as when a federally funded treatment guide (Jenner & Lee, 2008) advocates the use of the SDS (Topp & Mattick, 1997a) as a tool for the assessment of methamphetamine dependence. However, more broadly these claims are not explicated but underlie statements such as the following:

A large proportion of ATS dependent people will experience psychological problems including anxiety, depression and psychosis. (Ministerial Council on Drug Strategy, 2008, p. 6)

This statement, found in Australia’s national ATS policy, is only possible because of the scientific work that has inscribed methamphetamine in specific ways. As such, this work contributes to discourses that ‘undergird’ policy, practice and attitudes that stigmatise and scapegoat people who use drugs (Tupper, 2012, pp. 481-482). In this way, although the production of methamphetamine ‘facts’ purportedly aims to document methamphetamine-related harm, it also contributes to the pathologisation and further marginalisation of people who use the drug, impacting on the ways in which these individuals constitute and understand themselves (Pennay & Moore, 2010).

Yet, as STS scholars have argued, there are always other possibilities. If the ‘facts’ of methamphetamine are indeed made — are merely one version of reality among many — then it follows that there must be other ways of inscribing the materiality of methamphetamine that do not rely on the diagnosis of dependence or the prevalence of psychotic and violent behaviour amongst those who use the drug. In making this claim, I do not ignore the material effects of methamphetamine but seek to understand these effects as contingent. Moreover, when investigating drugs such as methamphetamine, researchers need to be acutely aware of the possible political effects of their work, taking responsibility to ensure that their methods and conclusions do not pathologise and marginalise already vulnerable populations. This might entail a shift from the investigation and surveillance of drugs and those who consume them to a focus on the assemblages of drug use; that is, to the ‘embodied, emotional, affective and material human and non-human interactions’ (Jayne, Valentine, & Holloway, 2010, p. 549) that come together in the act of drug use.

In later chapters of this thesis I take up the challenge to consider drug use as an assemblage rather than as emerging from the actions of a pathologised subject. In doing so, I reveal other ‘versions’ of methamphetamine, showing how the materiality of this object can be contested. Moreover, I show how scientific enactments of methamphetamine shape the practices of consumption and service provision, demonstrating the political effects of reifying methamphetamine as a toxic drug. In the following chapter, I shift from scientific literature to other authoritative texts — those produced in the fields of AOD policy, treatment and media — to interrogate the drug-using subjects they materialise. In doing so, I explore the ways in which methamphetamine, as it is reified in scientific literature, is taken up in the broader sphere and how this shapes our understandings of people who use it.

## Chapter 5: Extreme ‘absolutes’: Methamphetamine-using subjectivities in policy, treatment and media texts

### Introduction

In the previous chapter, I began addressing the first part of my research question by examining the ways in which methamphetamine and methamphetamine-using bodies are constituted in scientific, policy, treatment and media discourse. I presented post-structuralist and STS arguments that scientific knowledge is, like any form of knowledge, enacted and contingent. I then used theoretical tools from this body of work to analyse some of the ways in which methamphetamine is materialised in scientific literature as a specifically potent, addictive and harmful drug. I argued that scientific texts are not merely reports of scientific practices that describe the pre-existing substance ‘methamphetamine’. Rather, publication is scientific practice (Law, 2004) and along with an array of other activities — ranging from clinical assessments of methamphetamine users to observations of rats injected with methamphetamine — it ascribes various properties to methamphetamine, making it ‘real’ in particular ways. To make my argument, I traced some of the ways in which the materiality of methamphetamine has been reified in scientific literature, illuminating political choices and contradictions in this body of work, and demonstrating the contingency of methamphetamine ‘facts’. I then used theoretical concepts from STS to argue that facts are only very limited and political representations of reality, and to posit that the singular way in which methamphetamine has been inscribed is shaped by the available scientific and AOD hinterlands. I contended that inscribing methamphetamine as a highly addictive and potent substance requires positioning people who use this substance as pathological and/or transgressive, and as addicted or at risk of addiction. In the case of ice users, these individuals are hyper-aggressive and hardcore. I also argued that considering the materiality of methamphetamine as a matter of concern (Latour, 2005) rather than as the sum total of various scientific facts might lead to a more nuanced understanding of the drug and less pejorative ways of perceiving the individuals who use it.

I now build upon this argument, addressing how methamphetamine-using bodies are constituted in authoritative texts from the fields of policy, treatment and media. I shift my focus from scientific literature to these areas in order to address how the issue of methamphetamine consumption is produced and reproduced in a wider public sphere. This is necessary because while scientific knowledge is considered to underpin all truth, in its ‘raw’ form (such as scientific reports and journal articles) it is accessed by a relatively small group

of professionals. In order to explore the ways in which methamphetamine is more generally constituted and the political effects of this knowledge, it is necessary to consider the way in which these truths are replicated and constituted more broadly. Exposing the ways in which methamphetamine-using bodies are constituted in authoritative texts is an important step in addressing my research questions. In this chapter, I argue that these bodies have limited ontological possibilities — that they are shaped by epistemic assumptions. Then, in the empirical chapters that follow, I show how people who use methamphetamine and harm reduction and/or treatment practitioners may draw upon, resist and/or subvert these dominant constitutions of methamphetamine-using subjects and, in doing so, illuminate various aspects of the ontological politics of this drug.

Before I present my argument, however, I briefly outline the texts I explore in my analysis, how they function as ‘practice’ and why they are authoritative. I also present a key theoretical concept that I will use in this chapter; that is, the idea of embodiment as produced through, and productive of, practice.

### **Authoritative texts as practice**

Policy, treatment and media documents are authoritative as they are produced by powerful bodies and/or institutions such as government, the medical profession and media corporations. Their validity is also established because they are reputedly based on fact; policy and treatment are ‘evidence-based’ (see, for example, Jenner et al., 2006a; Ministerial Council on Drug Strategy, 2011), while media reports on ‘reality’. In the same way that the act of peer review and publication is constitutive of scientific practice (Latour & Woolgar, 1986), the production of policy, treatment and media texts similarly constitutes practice in each of these fields. To ‘do’ policy one must undertake activities such as consultation, negotiation and research. A key policy practice, however, is the production of written texts that are then referred to as ‘policy’ (Bacchi, 2009). Likewise, the practice of AOD treatment involves many activities including the provision of pharmaceuticals, the assessment and categorisation of individuals, counselling and detoxification. Central to the practice of treatment is the production of treatment guides or manuals. These texts are the culmination of existing evidence; they define ‘best practice’ in terms of treatment provision. The practice of media, like policy and treatment, comprises myriad procedures. A fundamental aspect of media practice is the production of images, text and sound for public consumption — including television news reports and documentaries (Bräuchler & Postill, 2010). Media practices evoke compelling realities as they are embedded within strong narratives (such as

film or documentary) and because they are often visual. They are also circulated more widely than policy or treatment texts and, in this sense, the media can be considered as a series of powerful performative practices.

In order to examine the way that policy, treatment and media texts constitute particular methamphetamine-related subject positions, I have selected texts that are of particular significance in their field, widely circulated and typically generated through federal government support. The policy text that I examine is the *National Amphetamine-Type Stimulant (ATS) Strategy 2008-2011* (Ministerial Council on Drug Strategy, 2008). As national policy, this strategy is central to way in which methamphetamine use is addressed in Australia. It is the culmination of a comprehensive national consultation and involved the establishment of a project management group and three reference groups made up of Australian experts in the areas of law, research and health (Ministerial Council on Drug Strategy, 2008, p. 9). While the strategy pertains to ATS generally (psychostimulant drugs that include meth/amphetamines as well as 3,4-methylenedioxy-N-methylamphetamine (MDMA or 'ecstasy'), rather than methamphetamine specifically, a word count suggests its focus is mainly methamphetamine. The term 'methamphetamine' or 'meth/amphetamine' is used 23 times in the document itself and there are nine bibliographical references concerning its use. The terms ecstasy or MDMA are used ten times in the document and have three bibliographical references.

The treatment texts I analyse to explore the constitution of methamphetamine-using subjectivities are: *Treatment approaches for users of methamphetamine: A practical guide for frontline workers* (Jenner & Lee, 2008); *A brief cognitive behavioural intervention for regular amphetamine users: A treatment guide* (Baker et al., 2003) and the website *meth.org.au* (archived at [webcitation.org/60KY14pTL](http://webcitation.org/60KY14pTL)). The treatment guide for frontline workers (Jenner & Lee, 2008) is a comprehensive manual that was funded through the National Drug Strategy. It is authored by two experts in the area of methamphetamine who have published numerous reports and articles on treatment (see, for example, Jenner & Lee, 2008; Jenner & McKetin, 2004; Jenner & Saunders, 2004; Lee et al., 2007; Lee, 2004; Lee, Pohlman, Baker, Ferris, & Kay-Lambkin, 2010; Lee & Rawson, 2008). The cognitive behavioural intervention (Baker et al., 2003) is a guide to undertaking a brief CBT intervention with stimulant users and is also a National Drug Strategy publication. The research used as a basis for this text was published (see Baker et al., 2005) and has contributed to the evidence base that posits that CBT is the preferred response to

methamphetamine use (see, for example, Lee et al., 2010). *Meth.org.au* was a website established for people who use methamphetamine, along the principles of self-help and incorporating CBT strategies. While no longer live, the website was active between 2007 and 2014. It was established and managed by Turning Point Alcohol and Drug Centre using national government funds.

I also examine a series of manuals for frontline workers about how to manage methamphetamine users, including ambulance officers (Jenner, Spain, Whyte, Baker, Carr, et al., 2006b), emergency departments (Jenner, Spain, Baker, Carr, & Crilly, 2006a) and police officers (Jenner, Baker, Whyte, & Carr, 2004). While these are not strictly treatment manuals, they do concern the management of methamphetamine users in health services and/or when experiencing a severe health-related issue such as psychosis. For this reason I have included them in my analyses, and also because as a series of documents they are an unprecedented response to illicit drug use, whereby the use of a specific drug is seen to require a suite of instruction manuals on managing and controlling a unique group of drug users.

Finally, I examine a seminal media report on methamphetamine, *The Ice Age* (Carney, 2006), an ABC documentary televised on the investigative journalism program Four Corners. I have selected this particular report as it was the first significant media report on the purported resurgence of methamphetamine in the 2000s and because, as a well-regarded and respected current affairs program, Four Corners is an authoritative media source. Rather than seeking a wide range of texts from each field, I have selected texts that are central to the way in which methamphetamine use is governed, made or known in a particular arena. I now outline the theoretical approach I use to discuss the subjects constituted within the selected documents.

### **What can a body do?**

To reveal the extreme absolutes of methamphetamine-using subjects materialised in policy, treatment and media texts, I employ a Deleuzian<sup>11</sup> interpretation of subjectivity and embodiment as interpreted by Ian Buchanan (1997). Several scholars have used Buchanan's work to explore the relationship between medicine, health and bodies (see, for example, Fox & Ward, 2006; Potts, 2004). Buchanan (1997) focuses on the capacity of the body to form specific relations and links to other bodies (p. 80). He argues that considering the question 'what can a body do?' as constitutive is a way to think of the body as 'the sum of its

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<sup>11</sup> I use the term 'Deleuzian' here, however, in doing so I acknowledge that crucial to Deleuze's work on subjectivity were his publications with Felix Guattari including *A Thousand Plateaus* (1987) and *Anti-Oedipus; Capitalism and Schizophrenia* (1983).



capacities' (Buchanan, 1997, p. 75). Focusing on what bodies can do, including their capacity to form relations, entails focusing on practice. A body is not prior to practice; it is recognisable through practice and changes as practice shifts. Thus, identity and personhood is not external to, or antecedent to, practice/action, it is produced through practice, including the connections and relationships people form.

Buchanan's (1997) interpretation of Deleuze's theory of embodiment enables an interrogation of methamphetamine-using subjects enacted in policy, treatment and media texts that moves beyond a pre-existing, sovereign subject. This reconfiguration of the body is a beneficial way to consider the drug-using subject. It requires thinking of:

practices of self for themselves instead of interpreting them according to the dictates of a previously stipulated clinical condition. (Buchanan, 1997, p. 75)<sup>12</sup>

This is a politically liberating way of considering embodiment, particularly for those individuals who engage in highly stigmatised activities such as methamphetamine use. A conventional 'Euro-American' (Law, 2004, p. 24) account of the body considers drug users as pathological and/or transgressive individuals. These individuals have these particular characteristics prior to practice, and practice is assumed to be a response to these characteristics. Buchanan, however, uses Deleuzian insights to argue that practice makes bodies with pathological and/or transgressive capacities; thus bodies are constituted and capacitated through practice. Key to recognising bodies in this way is to scrutinise practice and identify the capacities of the bodies produced. Therefore, I ask 'what can a body do?' of the methamphetamine-using subjects constituted in authoritative methamphetamine documents. I attend to their capacities and the practices that enact these capacities. I look at differences between the various bodies that emerge in these texts, but also note their common thread which is shaped by the current 'conditions of possibility' (Law, 2004, p. 35).

In the sections that follow, I discuss some of the ways in which policy and treatment texts enact hyper self-controlled, knowledgeable and self-aware methamphetamine-using subjects. I note the slippages evident in the enactment of these 'active' subjects and the tensions that arise when they interact with the substance 'methamphetamine'. I then track

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<sup>12</sup> It should be noted that Buchanan (1997) and Deleuze and Guattari (1987) offer a bleak interpretation of the 'drugged body' (Malins, 2004). Nonetheless, the theoretical tools offered by these scholars are helpful for understanding drug use in a way that moves beyond the pathological subject as the focus of investigation and for studying the practice of drug use itself as other than the actions of a deviant subject. Malins (2004), Keane (2002) and Duff (2007) have all demonstrated ways in which the theoretical insights of Deleuze and Guattari and their understanding of subjectivity can be applied to develop a more nuanced and complex understanding of drug use.

methamphetamine-using subjectivities enacted in binary opposition to self-controlled users. These are drug-using subjects who are anxious, depressed, psychotic and chaotic, found in policy, treatment and media texts. I examine the way in which these drug users are constituted as resistant or even as objects of disgust.

### **ATS policy: Knowledgeable, self-controlled bodies**

I first look at the way/s in which *The National Amphetamine-Type Stimulant Strategy 2008-2011* (Ministerial Council on Drug Strategy, 2008) enacts knowledgeable and self-controlled methamphetamine-using bodies. As I have argued previously in this chapter, while the strategy as a whole is directed at ATS, methamphetamine is its main concern. The strategy evokes multiple practices to address ATS use, including law enforcement and treatment. However, the central aim of the ATS strategy is to:

Reduce the availability and demand for illicit amphetamine-type stimulants and prevent use and harms across the Australian community. (Ministerial Council on Drug Strategy, 2008, p. 1)

Policing practice is central here, as indicated by the commitment to reduce availability of ATS. However, the aims to reduce demand and prevent use and harms involve providing knowledge so that the Australian public is informed about ATS. The primacy of this practice is signalled by the first listed objective of the strategy:

Increase the Australian's community's knowledge about amphetamine-type stimulants and raise awareness of the problems associated with their production and use. (Ministerial Council on Drug Strategy, 2008, p. 1)

This information is made available with the expectation it will be used to 'prevent and reduce' (Ministerial Council on Drug Strategy, 2008, p. 27) problems associated with ATS. Thus, all Australians are expected to act upon ATS-related knowledge to prevent and reduce harm, including ATS users themselves.

The provision of information with the expectation that an individual will act upon this information constitutes the neo-liberal citizen. These are citizens that self-regulate according to dominant doctrines of health, individuals that actively take responsibility for their well-being making choices that maximise their health (Rose, 2007). Making available health and harm reduction information to people who use drugs is an ongoing strategy to address illicit drug use in Australia (Moore, 2004; Moore & Fraser, 2006). While not denying the worth of

such activities, these practices are shaped within the current neo-liberal episteme, where even drug users must take responsibility for their own well-being and knowledge.

The role of the individual drug user in the ATS strategy is thus to absorb and act upon information, thereby reducing ATS-related harm. For instance, Priority Area 1 of the strategy concerns identifying how much people know about ATS and then addressing any gaps in knowledge. To do so, this text promotes the use of ‘social marketing and targeted strategies to raise awareness of the risks associated with ATS use’ (Ministerial Council on Drug Strategy, 2008, p. 17). Some of the messages that the policy promotes are the risks of combining ATS use with alcohol, the social unacceptability of ATS use, the risks of ingesting drugs containing unknown chemicals, mental and physical risks, and treatment options (Ministerial Council on Drug Strategy, 2008). Social marketing and the provision of health promotion in this context is a fairly traditional method of harm reduction, and the strategy also aims to find new ways to provide ATS users with knowledge to assist them to reduce harm. For instance, in Priority Area 4, ‘Problems associated with ATS use’, the strategy notes the need to:

Develop, trial and adopt innovative strategies for ATS users, to provide information about risks associated with ATS use, recurring ATS problems, understanding treatment options and seeking help. (Ministerial Council on Drug Strategy, 2008, p. 27)

While ‘innovative’ methods are suggested, the content of the messages relayed are consistent. People are to be informed about the ‘risks’ of ATS use, potential problems that may arise and where to seek help.

These practices, innovative or not, materialise ‘harm reduction’ bodies that, given the correct information, have the capacity to manage their ATS use, preventing and reducing risks and seeking help or treatment if necessary (Fraser & Moore, 2008; Moore, 2009). The provision of information in this way may be useful to many individuals, but it also has particular effects. Moore (2009) finds that harm reduction practice obscures the environments in which drug use takes place. He argues that while people may have the requisite knowledge to alleviate harm or risk, the networks that produce their drug use may limit their capacity to implement this knowledge (Moore, 2009). By making these elements of drug use absent, sole responsibility to alleviate drug-related harm resides with the individual. Also, the ‘harm reduction’ body makes drug use a rational exercise. Enacting this body assumes, for instance,

that people will change their drug use practices if they are aware of the risks. This assumption ignores the multiple reasons that people engage in drug use. There may be instances where people's drug use is driven by a desire to experience risk and danger (Fraser & Moore, 2008). Neglecting some of the very reasons that people seek to use drugs, such as risk and pleasure, means that the messages of harm reduction do not reflect the lived experiences and desires of people using drugs.

In critiquing the practice of harm reduction, I do not intend to negate it. There are obvious benefits to providing people who use drugs with information and resources that may assist them to mitigate any potentially harmful effects. Thus, it is helpful to consider Keane's (2003) argument that harm reduction is usefully conceptualised as an assemblage of practices and technologies with varied outcomes. Here, the practice of providing information to reduce harm constitutes a methamphetamine-using body with the capacity for knowledge. Yet, myriad events, objects, subjects and spatial and temporal considerations at play in the event of drug consumption will affect whether that knowledge is able to be deployed. This acknowledges the significance of the provision of information concerning the safer use of drugs while shifting responsibility for implementing this knowledge from the individual consuming drugs. Harm reduction bodies, then, may be knowledgeable, but the environmental and social circumstances of their drug use are also implicated in their capacity to put this knowledge to use and in socially approved ways. So, while as a strategy harm reduction has value, unless we consider agency as dispersed throughout the assemblages of drug use, we risk enacting these subjects as individually responsible for drug-related harm (Fraser, 2004).

### **'Active therapy': Treated methamphetamine-using bodies**

Having established that the national policy document concerning methamphetamine use in Australia enacts bodies with the capacities of the neo-liberal citizen (with its emphasis on harm reduction), I now turn to the practice of treatment as it emerges within three significant treatment texts. While methamphetamine harm reduction bodies are perhaps similar to drug-using bodies enacted through harm reduction strategies more broadly, 'treated' methamphetamine bodies are very specific, as they are hyper-agentive. I trace this specificity in this section.

As with harm reduction strategies, the provision of treatment for methamphetamine use is an integral part of the Australian Federal government's response to this drug. The national

strategy aims to ‘establish an adequate, effective and accessible range of ATS treatment options’ (Ministerial Council on Drug Strategy, 2009, p. 2), and government-funded guidelines concerning methamphetamine are available (see, for example, Jenner & Lee, 2008; Lee et al., 2007; Smout, 2008). Thus, there is a significant body of state-funded, evidenced-based methamphetamine treatment literature in Australia that deserves attention when considering the methamphetamine-using subject. Predominant in this literature is the practice of CBT, so in order to address treated methamphetamine-using subjects I examine CBT and behavioural therapies in general, as well as the closely related practice of self-help. I then compare the treated methamphetamine-using body with that of another highly stigmatised drug body — the heroin-using body — to explore how the materialisation of these entities is shaped by our understandings of addiction and how, in turn, the way we understand different types of addiction shape the practices that address drug use.

Scientific literature finds behavioural therapies to be a promising intervention for methamphetamine use (see Baker et al., 2005; Lee et al., 2010; Lee & Rawson, 2008; Rawson et al., 2002). Reflecting this evidence base, *Treatment approaches for users of methamphetamine: A practical guide for frontline workers* (Jenner & Lee, 2008) sanctions CBT as the preferred strategy to address methamphetamine use. In the introduction to this monograph, the authors state:

Numerous high-quality studies have suggested that psychosocial treatments, especially cognitive behaviour therapy (CBT), should be a standard intervention in methamphetamine treatment. CBT also assists with mental health problems, such as depression and anxiety, which are common among methamphetamine users. (Jenner & Lee 2008, p. 2)

Accordingly, while numerous treatment responses to methamphetamine use are outlined in the manual — such as brief intervention, counselling, residential rehabilitation and self-help groups — CBT is highlighted. For instance, in a summary of available treatments for methamphetamine the manual states:

**Cognitive behaviour therapy** has been evaluated most extensively and is effective for a range of problems related to methamphetamine use, including mental health problems such as depression and anxiety. (Jenner & Lee, 2008, p. 8, bolding in original)

Thus, the practice of CBT is promoted in this manual as the preferred standard response to methamphetamine use and its purportedly related issues — depression and anxiety. However, the bodies enacted by CBT practice are shaped by the assumptions of neo-liberalism and have political implications. The aim of this practice is to change the erroneous ways in which people think:

Cognitive behavioural approaches are short-term, focused, talking therapies that aim to identify and address common errors in thinking and subsequent behaviours that lead to, and maintain, problematic drug use. (Jenner & Lee, 2008, p. 58)

Here, using drugs problematically is linked to erroneous cognitive processes — resulting in problematic behaviour. These are citizens that cannot make the correct choices. The statement made above assumes that psychotherapy — in this case CBT — is a technology that can rectify this state. In this light, CBT is a practice that can transform non-citizens into functional, choosing citizens:

Selves unable to operate the imperative of choice are to be restored through therapy to the status of the choosing individual. (Rose, 1999, p. 231)

Moreover, by considering problematic drug use as the result of dysfunctional thinking, this statement responsabilises the methamphetamine-using subject. The subject is evoked here as the sole actor in the practice of drug consumption. This means that other elements that may have some bearing on problematic drug use, such as poverty, homelessness, lack of family support and a general dearth of social and economic resources, are ignored. CBT bodies thus assume responsibility (and blame) for their problematic drug use as this is apparently driven solely by dysfunctional thought patterns (Proctor, 2008).

While this treatment guide (Jenner & Lee, 2008) espouses CBT as the preferred response to methamphetamine use, it does not outline or suggest specific CBT techniques to apply when working with clients. Rather, workers are directed to find CBT practitioners in their area (see Jenner & Lee 2008, p. 59). An earlier publication, *A brief cognitive behavioural intervention for regular amphetamine users* (Baker et al., 2003), however, details a brief intervention based on CBT principles. The intervention was developed through research with amphetamine users and is designed specifically for them. Although the intervention is directed at amphetamine use (presumably amphetamine sulphate), the report of the intervention notes ‘[t]here has been a world-wide increase in the use of amphetamines, particularly methamphetamine’ (Baker et al., 2005, p. 100). This statement suggests that

methamphetamine is also a drug of concern. Nonetheless, the term ‘amphetamine’ is then used throughout the article. As noted in Chapter Four, while methamphetamine is often delineated from amphetamine as a ‘different’ and more harmful drug (see, for example, Baker & Dawe, 2005), it is also collapsed with amphetamine when necessary, particularly in cases where there is limited evidence on methamphetamine. This being the case, the research reported in the intervention described in Baker et al. (2003) has contributed to the general evidence base concerning methamphetamine (see, for example, Lee & Rawson, 2008; Shearer et al., 2009) and is even cited as an intervention ‘specifically for methamphetamine users’ (Lee & Rawson, 2008, p. 311; Shearer et al., 2009, p. 104). Having noted this slippage, in the discussion that follows I refer to the substance being addressed by the intervention as ‘meth/amphetamine’.

*A brief cognitive behavioural intervention for regular amphetamine users: A treatment guide* (Baker et al., 2003) contains guidelines for a two- or four-session brief intervention to address meth/amphetamine use, including detailed instructions for practitioners and client worksheets. Sessions typically involve going over ‘homework’ and ‘diaries’ from the previous session, and going through the reasons and triggers that might cause one to use meth/amphetamine, talking about these in detail and then setting goals for the next session. An example, of what takes place within sessions and the type of homework required is found in the following text introducing the second session:

Completing an urge diary over the past week will have given the client insight into the trigger situations that lead them towards experience of a craving. They will have practised identifying the elements of the trigger situation itself, along with their responding thoughts, feelings and behaviours. Now it is time to put those observations to use in helping them to better manage their craving situations. By learning techniques to cope with each aspect of the client’s experience of a craving, they can be more confident of ‘surviving’ that situation without acting on their urge to use speed. (Baker et al., 2003, p. 38)

Here, the client is required to document their cravings and urges to consume meth/amphetamine and then to scrutinise these in order to identify the ‘elements of the trigger situation’. They are expected to then use this information about themselves to exercise self-control.

The practice of assessing and managing one's thoughts, environments and 'trigger situations', along with the obligation to complete tasks such as diary keeping, is truly 'active therapy' (Baker et al., 2003, p. 12). If we then consider practice as constitutive of particular bodies (Buchanan, 1997), a meth/amphetamine CBT-treated body constitutes itself through scrutinising its own desires, thoughts and actions with the aim of exercising self-control. This practice is no doubt appealing to many people who use meth/amphetamine, in that it provides them with the means to embody themselves as self-controlled individuals. However, CBT has received critical attention primarily for the ways in which it acts as a technique of governance. For instance, Rose (1999, 2007) argues that behavioural therapies are practices that teach people to self-regulate in accordance with dominant norms and ideologies, where 'thought works on thought itself' (Rose, 2007, p. 101). Thus, rather than being a collaborative and self-empowering practice, CBT involves the client acquiescing to a more authoritative body of thought — that put forward by the therapist (Proctor, 2008). Ultimately, clients are expected to internalise the techniques conveyed to them by the therapist and become 'the surveyors and regulators of their own thoughts' (Proctor, 2008, p. 252). In this way, subjects reconstitute themselves as self-scrutinising, controlled individuals via normalising techniques made available by their therapist.

In terms of meth/amphetamine use, the active CBT body may seem preferable to the compulsive figure evoked by addiction and beneficial to individuals who use meth/amphetamine. However, as a practice, CBT responsabilises drug users to the point where all problems that they experience are located within erroneous thought patterns. This then masks the complexities of drug use and the way in which various networks and assemblages can produce problematic drug use. Further, while ostensibly a practice whereby the client achieves self-empowerment, CBT can also be conceived as a technique of government, as subjects assimilate values and norms espoused by their therapist and learn to embody themselves in ways consistent with dominant ideologies.

### **Self-help and 'expert drug users'**

Having considered the practice of CBT, I now turn to self-help. This is a highly active and self-driven practice. It mirrors the principles and assumptions of CBT — with a key difference; direct contact with a therapist is not required. Thus, this is a practice that enacts a highly active and controlled body. Self-help in the AOD sphere is usually associated with twelve step abstinence-based groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Crystal Meth Anonymous. The practice of self-help within the twelve



step movement is facilitated by a group fellowship involving mentoring and the attendance at regular meetings with fellow ‘addicts’. For the purposes of this discussion, however, I do not address self-help in the specific context of groups such as AA and NA but via the internet, an increasingly common location for self-help advice. I use Rimke’s (2000) and Rose’s (2007) understanding of self-help (and perhaps how this practice is more typically thought of in the wider sphere) as the individual pursuit of the ‘restoration of the self’ (Rose, 2007, p. 101). This approach to self-help assumes that it is underpinned by neo-liberal values such as ‘choice, autonomy and freedom’, and relies on ‘the principle of individuality and entail[s] self-modification and “improvement”’ (Rimke, 2000, p. 62).<sup>13</sup>

The website *meth.org.au* provides a clear example of self-help in relation to methamphetamine, as signalled by the slogan on its homepage: ‘Meth.org.au helping meth users to help themselves’. In order for users to help themselves, *meth.org.au* provides general information on methamphetamine, CBT strategies to manage thoughts/cravings and measure progress, and tools for self-diagnosis. Much of the information provided is harm reduction information — that is, advice or information that focuses on the potential harms of methamphetamine use, rather than on preventing methamphetamine use. However, in addition to this information, the website contains techniques and tools that oblige the user to self-categorise and self-reflect. One of the sections on the site is entitled ‘Take free test’. This is a self-diagnosis exercise in which individuals can determine if their methamphetamine use is ‘problematic’. To do this, the site uses the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (World Health Organisation ASSIST Working Group, 2002). As a screening tool, the ASSIST could be administered by a clinician as part of treatment practice. Yet, via *meth.org.au*, it is self-administered in order to assess one’s drug use and determine whether it is problematic or not. This is an example of Rimke’s (2000) observation that while ostensibly ‘self-treatment’, self-help projects are informed by ‘external forms of textual authority and expert knowledge’ (p. 62). Thus, in order to interpret one’s own methamphetamine use, a tool created and used by ‘experts’ is provided. It is not sufficient to merely *think* one’s methamphetamine use is problematic; this must be *validated* through the use of an expert tool.

Based on the results of the ASSIST questionnaire, users of *meth.org.au* can decide which part of the website is most appropriate for them. This might be a section on how to manage

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<sup>13</sup> For an analysis of twelve step self-help in relation to Rose’s theories of individualisation and autonomy, see Keane (2000).

unhelpful thoughts, how to maintain cessation from methamphetamine use or where to seek professional help. Almost uniformly, these sections involve a high level of activity. For instance, in the section on ‘Managing unhelpful thoughts’, users are asked to categorise what type of thinker they are (‘catastrophiser’, ‘personaliser’ and so on) and then to actively work to change this. As the following statement demonstrates, this process involves identifying unhelpful thoughts and then distancing oneself from these thoughts in order to better understand them:

Ask yourself ‘Which type of negative thought did I just have?’. Label your thoughts as ‘catastrophising’, ‘personalising’, ‘jumping to negative conclusions’, ‘black/white thinking’, or ‘shoulds/oughts’. When you separate yourself from the thought and give it a label, it’s amazing how quickly it loses its power over you. (*meth.org.au*)

The practices outlined here involve not only the capacity to assess whether specific thoughts are negative, but to then be able to categorise them. This obliges users of *meth.org.au* to ‘learn new ways of self-reflection, self-assessment and insight’ (Rose, 2007, p. 101) in order to control their methamphetamine use.

On examination of *meth.org.au*, it is apparent that self-help is very similar to CBT in that both practices are technologies that enable subjects to re-constitute themselves through thought and behaviour modification, guided in this practice by experts (albeit at a distance, in the case of self-help). Indeed, it could be argued that the expectation of CBT — that clients will become their own therapist — is taken to its logical conclusion with the practice of self-help. CBT and self-help bodies, similar to harm reduction bodies, offer people a way of considering drug users as capable, active and empowered human beings, challenging preconceptions about these individuals. Yet, the flip side of these active bodies is that a regime of self-scrutiny must be maintained in order to stay ‘treated’. This involves consistently evaluating one’s thoughts, monitoring trigger situations and managing cravings. It is a life of:

constant self-doubt, a constant scrutiny and evaluation of how one performs, the construction of one’s personal part in social existence as something to be calibrated and judged in its minute particulars. (Rose, 1999, p. 243)

Moreover, the evocation of the sovereign subject through the practices of CBT and self-help requires the point of intervention to be the erroneous thought patterns of this subject. This obfuscates the myriad subjects, objects, places and spaces that come to play in the event of

drug use. It may also hide inequalities that contribute to problematic drug use such as poverty and homelessness, effectively placing responsibility on individuals who experience these inequalities to change the way they think and behave in order to manage their drug use effectively. So, while appealing in some ways, the CBT/self-help subjects are unencumbered by the assemblages of existence (which may include homelessness, unemployment and incarceration) and are able to make choices and direct themselves in ways that may not reflect the lived experience of individuals who use drugs.

In critiquing the practices of CBT and self-help, I am not arguing that these particular treatment interventions are unhelpful. But it is also important to remain sceptical of the active CBT/self-help subject and to expose its limitations (Moore & Fraser, 2006). Does any individual have the capacity to undertake the consistent self-reflection and self-work required by these practices? Is the active, self-controlled, treated body specific to methamphetamine and, if so, why? I explore this point further in the section that follows by comparing methamphetamine and heroin treatment practices.

### **Active/passive treated bodies: Comparing methamphetamine and heroin treatment**

While treatment practices directed at methamphetamine use enact a hyper-agentive body, this is not the case for the treated heroin-using body. This is an important point for two reasons. First, heroin and methamphetamine are often compared in terms of their ‘addictiveness’ and destructive potential (see, for example, Darke et al., 2008; McKetin et al., 2005a) and, second, use of both drugs is alleged to result in addiction. Despite these commonalities, examining treatment guides for heroin (O’Brien, 2004) and methamphetamine (Jenner & Lee, 2008), both funded through the Australian Commonwealth Department of Health and Ageing, shows that very different treatment methods are espoused for each drug. Examining evidence-based treatment guides for these drugs and describing the different capacities of the bodies they constitute illuminates the limited and contradictory ways we have of thinking about addiction.

Broadly speaking, problematic methamphetamine use is considered treatable via the practice of CBT (Jenner & Lee, 2008). While there has been significant research into a suitable pharmacological agent to treat methamphetamine use, to date this has been unsuccessful. Heroin use, however, is treated primarily via pharmacotherapies in Australia and pharmacotherapy maintenance is considered ‘best practice’ in the scientific literature

(Mattick, Breen, Kimber, Davoli, & Breen, 2003; Mattick, Breen, Kimber & Davoli, 2014). Accordingly, the guide for heroin use, *Treatment options for heroin and other opioid dependence: A guide for frontline workers* (O'Brien, 2004) does not put forward CBT, or any other form of behavioural therapy, as a viable treatment for problematic heroin use. It focuses on the provision of pharmacotherapies, using three approaches: detoxification, substitution and abstinence. Detoxification involves the use of buprenorphine (O'Brien, 2004, p. 7). Substitution therapy involves the provision of methadone or buprenorphine (O'Brien, 2004, p. 12) and abstinence involves the use of naltrexone (O'Brien, 2004, p. 16). The heroin treatment manual notes that 'counselling and support services' (O'Brien, 2004, p. 18) are possibly beneficial to those using heroin, but states that these should occur in conjunction with other forms of treatment:

Most people agree that counselling on its own will probably not be enough to change dependent heroin use. Counselling and support services as a part of other treatments, however, can be more effective (e.g. substitution treatment with methadone or buprenorphine and counselling). (O'Brien, 2004, p. 18)

The significant point in this statement is that counselling is an adjunct to substitution treatment and not a stand-alone treatment practice. This is very different from the recommendations found in the methamphetamine treatment manual, in which talking therapies alone are considered the most effective and suitable form of treatment for this methamphetamine use.

It is also interesting to note the emphasis on psychiatric co-morbidity in the methamphetamine treatment manual (Jenner & Lee, 2008) compared to the heroin treatment manual (O'Brien, 2004), and the link between this purported co-morbidity and the practice of CBT. CBT is mentioned several times in the methamphetamine treatment manual as efficacious for the treatment of methamphetamine, as well as for anxiety and depression (Jenner & Lee, 2008, pp. 2, 6, 8, 58). Examining the scientific literature, however, reveals that people who use heroin are also reported to have high levels of these psychiatric disorders (Brienza et al., 2000; Darke & Ross, 1997; Havard, Havard, Teesson, Darke, & Ross, 2006; Lejuez, Paulson, Daughters, Bornovalova, & Zvolensky, 2006), with one study concluding that the high levels of depression and anxiety among heroin users had 'clinical implications' (Darke & Ross, 1997, p. 140). Yet the treatment text for heroin use contains very few mentions of depression and/or anxiety and no recommendation to actively treat these

disorders. Rather, it is stated that entering treatment may assist one's emotional health, including depression and anxiety (O'Brien, 2004, p. 3).

While there is very little mention of comorbidity in the heroin treatment manual, the treatment text on methamphetamine has an entire chapter on 'Recognising and responding to a person with mental health problems' (Jenner & Lee, 2008, p. 29). This is most likely related to the claim that methamphetamine use is associated with psychosis (an issue explored later in this thesis), but the chapter includes separate sections on anxiety and depression. Here, statements are made such as 'Depression commonly occurs among methamphetamine users' (p. 36) and 'It is common for methamphetamine users to experience some of these [anxiety] symptoms as a direct effect of the drug' (p. 38). These statements, along with others mentioned previously concerning the efficacy of CBT with regards to depression and anxiety disorders, enact these disorders as central to the treatment of methamphetamine use (Jenner & Lee, 2008, p. 2). And yet the evidence that informs these assertions is tenuous. For example, Baker and Dawe (2005) observe:

There has been remarkably little investigation of the course of amphetamine use and co-occurring psychological problems. (p. 89)

These authors also note 'diagnostic uncertainty' (p. 89) concerning depression and anxiety among amphetamine users, as symptoms of these disorders may be confused with the side effects of amphetamine use, rather than indicative of a stand-alone diagnosis. In relation to methamphetamine specifically, there is strikingly little evidence in relation to comorbidity, and what evidence exists is based mostly on research with amphetamine users (see, for example, Hall, Hando, Darke, & Ross, 1996; Vincent, Schoobridge, Ask, Allsop, & Ali, 1998). In citing these examples, I am not trying to assert whether rates of depression and anxiety are high among people who use methamphetamine. I do, however, wish to call attention to the centrality of these disorders to the treatment of methamphetamine, and their complete absence with regards to the treatment of heroin. This is so despite high levels of depression and anxiety reported among people using heroin and the problematic and uncertain relationship between methamphetamine use and anxiety and depression.

Thus examining practices in the two treatment documents for methamphetamine and heroin reveal bodies with very different capacities. Heroin-using bodies are medicated, and the pharmacological agents they consume address their cravings, manage their withdrawal symptoms and/or block the effects of their heroin consumption. These bodies are not obliged

to manage erroneous thought patterns, or address their depression and anxiety; instead they are made docile and compliant by the actions of the pharmaceuticals they ingest. They are ‘disciplined and addicted — but heroin-free — subjects’ (Bourgois, 2000, p. 184).

Methamphetamine-using bodies (as I have argued previously) are active in treatment, collaborating with their therapists in order to change the way they think and the associated behaviours. Moreover, these bodies are also obliged to address adjunct disorders such as depression and anxiety.

Yet, while treatment practices enact bodies with different capacities, both heroin-treated bodies and methamphetamine-treated bodies are ostensibly being treated for the same disorder — addiction. Tracing how this concept is mobilised in these two sets of treatment practices brings to light its multiplicity and the contradictory ways in which we constitute drug use. An assumption that underpins addiction in the current conditions of possibility is that it is a compulsive activity in binary opposition to voluntariness (Sedgwick, 1992). Thought about in this way, the heroin-treated body is not obliged to address its compulsivity.

Addictive practices — such as desiring a drug and taking drugs regularly — are not treated, but rather the body’s compulsive desire for heroin is sated with a form of legitimate medication. Methamphetamine-treated bodies, however, are obliged to address their compulsivity with practices that are highly voluntaristic. For methamphetamine use to be treated successfully, users must transform themselves from compulsive, addicted individuals to active and self-controlled individuals by monitoring and changing their thought patterns. However, given that both heroin and methamphetamine are considered highly addictive, how is it that methamphetamine-addicted bodies are constituted as specifically active and able to exercise high levels of voluntariness in their treatment? Investigating the assemblages of treatment illuminates the theories and tools that constitute methamphetamine and heroin-treated bodies in such different ways.

Key tools that shape, and are shaped by, the concept of addiction are inscription devices such as the DSM-V (American Psychiatric Association, 2014) and the SDS (Topp & Mattick, 1997a). These are tools which emphasise the psycho-social dimensions of addiction rather than its physical dimensions (Keane, 2002) and, as I have argued in Chapter 4, have enabled the constitution of methamphetamine as a substance of addiction (Topp & Mattick, 1997b). The ‘psycho-social’ nature of methamphetamine addiction is most logically addressed through ‘psy’ based treatments such as CBT (Jenner & Lee, 2008, p. 2). Heroin addiction, on the other hand, is inscribed as recognisable through primarily physical signs and hence the

dominance of heroin treatment practices that involve the substitution of acceptable opiates that ease physical withdrawal symptoms, either for the purposes of detoxification or maintenance (O'Brien, 2004). Thus the concept of addiction is a multiple object, variously constituted by different sets of theory and assemblages of drug consumption and drug treatment. In heroin treatment assemblages, the purportedly physically addictive properties of opiates and pharmacological agents such as methadone enact docile, treated bodies. In methamphetamine treatment assemblages, the emphasis on the psycho-social dimensions of addiction and a lack of pharmacological tools with which to treat this drug enacts active treated bodies, with adjunct psychological pathologies.

Moreover, while the treatment assemblages for heroin and methamphetamine appear to constitute a conventional mind/body dualism, recent developments in the area of brain science suggest a more singular understanding of addiction. Keane (2012) argues that the divide between the physical and psychological dimensions of addiction has been seemingly rendered obsolete with the rise of a neuroscientific paradigm within addiction science. In neuroscientific accounts of addiction, it is argued that changes in the brain's neural pathways are markers of addiction, and that these are consistent irrespective of the drug or behaviour to which one is addicted (Keane, 2012). Nonetheless, in spite of this new way of conceptualising addiction, Keane (2012) states that:

The scientific authority and institutional power of the brain disease model of addiction and its neurochemical perspective has not been translated into the clinical process of diagnosis. (p. 359)

This statement also applies to the broader treatment practices directed at heroin and methamphetamine addiction. If addiction is a brain disorder then it should follow that treatment practices are, to some extent, uniform, and applied irrespective of the drug or behaviour involved. Yet, as evidenced by the difference between the way heroin and methamphetamine are constituted through treatment, this is not the case. Instead, while methamphetamine treatment focuses on cognitive strategies, there is no requirement for heroin addiction to be treated in this way; it remains a singularly somatic disorder.

Keane (2012) also notes the strong significance attached to the physical signs of addiction, even with the rise of psycho-social and neurological explanations of addiction. This is evidenced by the continuing centrality of the physicality of heroin addiction as well as by the commitment to discover an appropriate pharmacological intervention for methamphetamine

use (see, for example, Elkashef et al., 2008; Heinzerling et al., 2010; Shoptaw et al., 2008). A lack of success in this area means that despite understanding methamphetamine as a highly destructive and addictive drug, we are unable to use pharmaceutical agents to intervene upon methamphetamine addiction. Instead, we are obliged to ‘make’ methamphetamine users active in their treatment – with all the capacities that entails. Yet the dangerous properties of methamphetamine remain, and these are problematic to the evocation of active and self-controlled methamphetamine-using subjects. I discuss some of these tensions in the section that follows.

### **‘Active’ methamphetamine-using bodies: Points of tension**

Methamphetamine is reified as a highly addictive and destructive substance. It reportedly results in individuals experiencing dependency, mental and physical health disorders, and engaging in violent behaviour (Darke et al., 2008). These characteristics all signal a low level of self-control and thus it becomes difficult to reconcile the hyper-active, self-controlled subject constituted through treatment, CBT and self-help practices with methamphetamine consumption. In this section I discuss some of the tensions evident in the materialisation of active, self-controlled drug-using subjects in policy and treatment texts, noting how tenuous these subjects are as they encounter ‘methamphetamine’.

As part of a Federal Government campaign to educate the public about the dangers of ATS use, between 2009 to 2011 a set of posters was displayed around Melbourne at bus and tram stops and in phone booths. One poster in particular, concerning the use of ice, illustrates the tension between the active, self-controlled methamphetamine-using body and the destructive capacities of methamphetamine (see [www.webcitation.org/6Sxg4qrlp](http://www.webcitation.org/6Sxg4qrlp)). The poster features a grey-faced man, perhaps in his early thirties, in a shirt and tie sitting at his work desk. The slogan ‘Ice will destroy his career. Then his life’ is written across this image. The man’s clothes and immediate environment signify that he is a professional. As someone with the capacity to work in a business environment, presumably earning a high income, he has the attributes of the neo-liberal citizen. Further, as he is also using ice, he is enacted as a high-functioning and agentic user. However, the man’s physical expression (he is slumped, holding his head in his hands), and most obviously the text, indicate the precarious nature of this subjectivity. It is inevitable that he will succumb to the destructive properties of ice, despite his obvious high-functioning capacities. The image and text convey the message that these capacities dissipate in the face of ice use.



Tensions between the way in which methamphetamine has been enacted in public and scientific discourse, and the manifestation of agentic methamphetamine-using subjects, are also evident at the website *meth.org.au*. In particular, two sections that deal with cravings illustrate these tensions. In the first section, entitled, ‘Want to help yourself?’, behavioural strategies are suggested to deal with cravings, including imagining a craving as a wave. The concept of craving is explained to users of the site in neurological terms:

Being exposed to things that you’ve associated with meth can cause a little squirt of dopamine a brain chemical messenger (neurotransmitter) involved in the control of physical movement, thinking, motivation, and feelings of pleasure or reward to be released in anticipation of the main event (meth) and the brain WANTS MORE. This is why it’s hard to get meth out of your mind for the first few minutes of a craving.  
(*meth.org.au*, capitalisation in original)

Here, the users of *meth.org.au* are enacted as knowledgeable and self-aware individuals who can understand a neurological explanation of what happens in the brain during a craving, and then can critically assess and control this squirt of dopamine when it occurs. Moreover, methamphetamine itself is described in terms of the residual effect it may have on neural pathways rather than as a particularly destructive and dangerous substance.

However, another section of *meth.org.au*, entitled ‘Don’t give up’, addresses urges to use or cravings in a different way. This section of the website states:

If you do slip up and have some meth (or more than you’d planned) don’t beat yourself up about it. The meth monster will probably try to sabotage you with messages like ‘I might as well keep using since I can’t stay off it’. But the truth is, you CAN...you HAVE...and you can STAY stopped or cut down. Tame the meth monster by thinking ‘OK, I’ve had some meth but it’s just been this once and I don’t have to have any more. I’m doing well and this is just a minor blip on the radar’.  
(*meth.org.au*, capitalisation in original)

In this case, the urge to use is not the result of a squirt of dopamine, but rather the ‘meth monster’. Methamphetamine as the meth monster has the capacity to compel people to use it, and cravings are no longer the actions of the neural pathways, but attributed to a malign agent — the meth monster itself. When enacting the figure of the meth monster, the text both reinforces the idea of methamphetamine as a destructive and evil substance, with inherent agency and, given that monsters are fantasy figures from childhood, materialises drug users

as childlike. Thus, while *meth.org.au* is a self-help resource enacting bodies with the capacity for self-treatment, able to understand the brain model of addiction and self-aware to the point they can ‘surf’ their craving ‘waves’, there are slippages that suggest these active, self-controlled bodies are susceptible to change. Methamphetamine’s materiality has been inscribed in such a way that it can become a meth monster; faced with the meth monster, the agentive subject’s capacities change and he or she becomes instead a childlike figure attempting to tame the monstrous properties of methamphetamine.

It appears then, that while policy and treatment practices materialise active, self-controlled, knowledgeable methamphetamine-using bodies with the capacities of the neo-liberal ideal, these can be difficult to sustain given the addictive and destructive properties of methamphetamine. Thus, these bodies are perpetually susceptible to losing their capacities and being re-constituted in perhaps more familiar ways — as addicted, as having lost everything and as childlike.

### **Resistant, anxious and paranoid bodies**

Calling attention to some of the slippages apparent in the materialisation of self-controlled methamphetamine-using bodies leads us to the more familiar figure of the addicted, compulsive, methamphetamine-using body — that is, those bodies lacking the capacity to exercise self-control, avoid harm and actively treat themselves. These subjects include those that require professional assistance to fulfil the obligations of the neo-liberal subject, those that are resistant to treatment, or anxious and paranoid, and those that are subsumed by methamphetamine. In the discussion that follows, I examine the ways these bodies are enacted through policy, treatment and media texts. I also consider some of the tensions evident in the constitution of these bodies due to the neo-liberal assumptions that inform health and AOD practices.

I have argued previously in this chapter that the Australian ATS policy (Ministerial Council on Drug Strategy, 2008) materialises agentive drug-using bodies through the practice of harm reduction. However, the figure of the non-agentive, drug-using subject also emerges through national ATS policy. For instance, the ATS strategy seeks to develop an evidence base in order to ‘manage severely dependent ATS users who are resistant to standard interventions’ (Ministerial Council on Drug Strategy, 2008, p. 29). A hyper-pathologised subject is enacted by this statement, one that is ‘severely dependent’ — with the lack of volition that this implies — and so unsuited to the usual interventions. The term ‘manage’ intimates that these

bodies require a level of supervision or direction consistent with a body of reduced capacity. At the same time the term ‘resistant’ suggests a body that is actively uncooperative. This body thus works against its own best interests by resisting interventions. This has the effect of locating the failure of standard interventions to work within the dysfunctional, ‘resistant’ subject and obscures other reasons for the failure of interventions, such as the nature of interventions themselves.

Other incarnations of ATS-using subjects with compromised agency can be found in the ATS strategy. The strategy document observes that:

the nature of many ATS problems means that a proportion of those who enter treatment may be experiencing anxiety and/or paranoia, and also find it difficult to establish and maintain relationships with clinicians. (Ministerial Council on Drug Strategy, 2008, p. 32)

This statement does not clarify what ‘the nature of many ATS problems’ are, or how they relate to individuals experiencing ‘anxiety and/or paranoia’. Yet, the subject that emerges has reduced capacities in that it experiences mental disorders and, due to these, it struggles to form relationships with professionals. Again, the implication is that the defective subject (not resistant in this case, but anxious and/or paranoid) is responsible for a lack of engagement with treatment and clinicians, rather than the treatment or clinicians themselves.

Thus, while a predominantly active subject is enacted in ATS policy — due to its emphasis on the practice of providing information to individuals with expectation they will act upon this information in the interests of their health — subjects of compromised agency are also enacted within this policy. The limited capacities of ‘severely dependent’ and ‘anxious and paranoid’ ATS-using bodies render them unsuitable candidates for standard treatment interventions. As such, poor treatment outcomes are able to be considered as a result of the dysfunctional ATS-using body, rather than other aspects such as the treatment itself. This means that the assemblages of AOD treatment — the spaces, clinicians, doctors, treatment guides, pharmacotherapies and other objects and subjects that produce the treatment encounter — are obscured.

Similar to policy concerning methamphetamine, treatment practices directed at the use of this drug also enact both active and non-active/resistant bodies. The national treatment guide for methamphetamine (Jenner & Lee, 2008) recommends that CBT should be standard practice in the treatment of this drug and, in doing so, materialises methamphetamine bodies that are

highly self-aware and reflective. Yet this manual also recommends practices that enact bodies with reduced capacity. For example, workers are advised that although the way methamphetamine works is complex, they must be able provide their clients with an understandable explanation:

The way in which methamphetamine works is complex, but it is extremely important for workers to understand how this drug works in the body so they can inform their clients....The end of this section contains a suggested plain language explanation that can be used by workers to help clients better understand the effects of methamphetamine. (Jenner & Lee, 2008, p. 15)

The information that workers are to provide to clients includes the following:

Methamphetamine causes the brain to release a huge amount of certain chemical messengers, which, as you probably know, make people feel alert, confident, social, and generally great....Think of a glass full of 'happy' messengers, so when people have been using methamphetamine for a while the glass empties and no matter how much methamphetamine they use they just can't get the rush they want and will still feel awful. (Jenner & Lee, 2008, p. 17)

In the above information for clients, technical language is eschewed for childlike descriptions of drug use. This enacts a body without the capacity for understanding the more complex information needed to act upon on his or herself. It notes, however, the extreme importance of the individual having access to this knowledge. These are bodies obliged to understand themselves in increasingly neurobiological terms (Rose, 2007). It is not enough to know that one may build up a tolerance after taking methamphetamine for some time; the individual is expected to comprehend (albeit in a limited way) what occurs at a neurobiological level and to use this information in the interest of his or her health and well-being.

The textual evocation of this methamphetamine-using body reveals some of the tensions between subjects with little or no capacity to act correctly upon themselves and the neo-liberal assumptions that underlie health practices (Lupton, 1996). The bodies that emerge in the practices outlined above are not able to fully assume the status of a neo-liberal citizen, as they do not have the capacity to understand complex information about themselves. Yet, with assistance from treatment practitioners they are still required to fulfil the obligations of the neo-liberal citizen. These obligations include understanding exactly what happens when they take methamphetamine to enable informed decisions.

## **Violent and toxic bodies**

In addition to resistant and anxious bodies, authoritative texts also enact methamphetamine users as violent and toxic. A suite of publications concerning the management of methamphetamine toxicity for front-line professionals not working specifically in AOD, including ambulance officers (Jenner et al., 2006b), emergency departments (Jenner et al., 2006b) and police officers (Jenner et al., 2004) is available through the National Drug Strategy website (*nationaldrugstrategy.gov.au*). These publications enact methamphetamine-using bodies very much at odds with the active and self-controlled user. This series of publications is indicative of the specificity of how we understand methamphetamine and those who use the drug. No other drug has prompted a series of similar publications by an Australian government body, testament to the way in which methamphetamine has been inscribed as a toxic drug that induces violent behaviour.

These three texts are all premised on the assumption that management of severely affected people using methamphetamine will involve addressing violent and/or psychotic behaviour. The text for ambulance officers explains:

Control of behavioural disturbance is the first priority. Calming communication to de-escalate potentially dangerous situations is recommended if a patient becomes hostile or violent in the pre-hospital setting. (Jenner et al., 2006a, p. v)

Guidelines for addressing this behaviour include talking calmly to the affected individual, avoiding eye contact, avoiding restraint (if possible) and, as a last resort, sedation with midazolam (a commonly used intravenous sedative). In addition to being hostile and violent, methamphetamine-using bodies materialised in these guidelines are also indistinguishable from mentally disturbed bodies. This is evident in the following statement:

It is often difficult for paramedics at the scene to accurately determine if an individual is intoxicated with psychostimulants or suffering from an acute mental health disorder. For this reason these guidelines recommend that both situations be responded to in the same way. Specifically, both are considered to be a medical emergency. (Jenner et al., 2006a, p. 7)

Here, the severity of the methamphetamine-using body is made clear, as managing this body constitutes a ‘medical emergency’.

In addition to being characterised as violent and psychotic, methamphetamine users are also enacted as ‘toxic’ in these publications. Police guidelines outline the difference between intoxication and toxicity as follows:

Individuals experiencing psychostimulant *intoxication* can often demonstrate a range of behaviours related to the stimulating effects of the drug including mild paranoia, rapid speech, irritability and agitation. However, when a person is *toxic* or has a poisonous level of psychostimulant in their system, a range of behaviours including escalating psychosis, acute paranoia, aggression, marked agitation or violence may be evident. When in a state of toxicity, an individual’s behaviour may pose a significant risk to the physical safety of themselves, bystanders and police officers. (Jenner et al., 2004, p. viii, emphasis in original)

Asserting that a person is toxic is used here to delineate a state beyond intoxication. In this state, it appears a methamphetamine users may engage in a range of frightening behaviours and require intensive management. Thus, methamphetamine-using bodies in these texts are enacted in binary opposition to the agentive body materialised in CBT practice. These are specifically violent, toxic and possibly insane bodies.

### **Subsumed, disgusting and depraved bodies**

By examining policy and treatment texts I have shown that two opposing spheres of methamphetamine-using bodies — active and self-controlled compared to anxious, resistant and violent — are enacted within these documents. Further, these bodies are enacted in extremes — they are hyper-controlled, and at the same time hyper-violent and psychotic. I now turn to the field of media, in order to further examine the extreme absolutes of methamphetamine. Here I find a familiar figure of drug use, that of the chaotic and out-of-control ice-using body. This body has compromised agency. It is unable to exercise volition as its actions are driven by the drug ice itself. It is an important body to consider when discussing the way we constitute people who use methamphetamine, as media texts reach a very broad audience.

*The Ice Age* (Carney, 2006) is a documentary focusing on the use of ice in Australia and the harms that may occur. To do this, it features a group of people who experience a high degree of social and economic deprivation, including homelessness, estrangement from family, incarceration, poverty and mental illness. This group of ‘hardcore ice addicts’ is followed around the streets of Sydney and is filmed buying and using methamphetamine and other

drugs. A key figure in the documentary is ‘Matty’, an individual who is filmed living on the streets, confessing to various criminal acts, taking drugs and being heavily intoxicated. The footage of Matty (as well as other participants) is so revealing it is difficult to comprehend the circumstances under which these individuals would have given consent to being filmed. It is perhaps their social marginalisation and vulnerability, rather than their being representative of typical ice users, which has resulted in their participation in the documentary.

A feature of the documentary (signalled by its title) is the emergence of the substance ice, a specifically dangerous, destructive and addictive substance, and a threat to the Australian population. This is made clear from the opening statement of the report:

It's more destructive than any other drug Australia has ever seen. It's cheap and it's highly addictive. It's not heroin, but ‘ice’ or crystal methamphetamine, the most potent amphetamine ever to hit our streets. Its powerful high can last for days or weeks. In Australia, there are now more ice addicts than heroin addicts. (Carney, 2006)

This strongly worded passage evokes an emerging catastrophic drug problem: a cheap drug, that is so potent its users can be ‘high’ for weeks. And to clinch the characterisation of ice as extremely addictive, it is compared to heroin — a popular media benchmark for assessing how dangerous a drug is (see, for example, Bartlett, 2006; Hayes, 2006).

Following this statement, scientific authority is used to authenticate the reporter’s assertions regarding ice. Professor Ian McGregor, a psychopharmacologist, is interviewed and states:

Methamphetamine, in my experience, looking at both animal studies, studies of laboratory animals and addict populations, it's one of the most addictive drugs that we know, and it's by virtue of its ability to produce this huge surge in dopamine levels. (Carney, 2006)

Later, McGregor says:

So, if dopamine's constantly being over-produced and over-released, then the brain will down-regulate the receptors that dopamine binds to, so you'll alter the function of the brain. So, you end up with a bit of an abnormal brain as a result of methamphetamine. (Carney, 2006)

As McGregor is a scientist, his assertions are difficult to refute. This is made evident by his title, but also by the content of his statements. He uses technical language and imagery, referencing brain science. Thus, from the outset of the documentary, the substance ice, or

methamphetamine, is enacted as a threat to society, neurally damaging to the individual and addictive. Inscribing ice in this way leaves little doubt as to the capacities of ice-using bodies. These bodies will be necessarily addicted, but also high and brain-damaged.

A strong theme within this documentary is the way in which ice (and heroin) takes over human existence. Ice-using bodies are enacted in this text as wholly enmeshed within addiction itself. An example of this is provided in the telling of Mick's history:

This is the only life Mick has ever known. He started his addiction with heroin when he was just 13. Now 36, he's been in and out of jail for the last 13 years. (Carney, 2006)

In this statement, ice, heroin and incarceration are the sum total of Mick's existence. These elements apparently trump any other connections, relationships or practices that Mick has engaged in during his life. And indeed, Carney goes on to assert that drug use can subsume personhood. Talking about two participants in the documentary Carney states, 'for Mick and Matty, drugs have created and completely defined their identities' (Carney, 2006). Here, Mick and Matty's subjectivity — how they experience the world — is reduced to their drug use, rather than any other experiences they may have had. Their identities are shaped entirely by their drug use; they are solely drug bodies. As drug bodies they live in a 'drug cycle' and their day-to-day life is described as follows:

They live in a drug cycle of about two weeks. For the first week, they take ice and barely sleep or eat. The following week, they crash and sleep until the next welfare cheque. Then the cycle starts again. (Carney, 2006)

The methamphetamine-using subjects enacted within this text are thus controlled and subsumed by ice so that everything they do, and everything they are, is related to ice and addiction.

As well as being controlled by ice, the documentary portrays methamphetamine bodies as 'grotesque' objects of disgust and depravity (Moore, 2008, p. 357). Documentary participants are filmed rummaging through rubbish, picking at themselves, living in squalor, and speaking incoherently while 'under the influence' of methamphetamine and other drugs. A doctor working at an accident and emergency department in inner-city Sydney describes a 'very extreme case' where a patient masturbated for 16 hours in full view of staff and other patients (Carney, 2006). 'John' is interviewed, who 'is convinced that he is infected with ice bugs,



parasites that he believes were living in a bad batch of ice he injected years ago' (Carney, 2006). John states:

As you can see, there's something under the skin and it's coming through. All up here, my leg. I've been using that wash, and as you can see, they come up. This, when it was at its worst, was real pussey [sic] in the centre. And you used to be able to squeeze it, and little spores would come out. And they had this red stuff around them, which was very sticky. (Carney, 2006)

With these images, the documentary enacts ice-using bodies as disgusting and depraved. In doing so, a group of people who are obviously socially marginalised are further estranged from 'normality'. As objects of disgust, these people do not evoke a response of empathy, but revulsion, serving to further entrench their marginalisation. The participants of this documentary are individuals entangled with phenomena such as sleeplessness, psychosis, poverty, masculinity and other drug use. Yet, *The Ice Age* constitutes them as fuelled by methamphetamine — othering their complexity, rendering them easily understandable.

To conclude, the ice-using bodies enacted in *The Ice Age* are brain-damaged, subsumed by ice, living a drug cycle and engaging in disgusting and depraved acts. These bodies are failed neo-liberal citizens. They are the binary opposite to the self-managing harm reduction, treatment and self-help bodies enacted in neo-liberal health practices. This is reflective of the chaos/stability binary that Fraser and Moore (2008) argue is a mainstay of illicit drugs discourse. The authors argue that this binary entails that drug users are chaotic and non-drug users are not, or that some drug users are chaotic and other drug users are orderly (Fraser & Moore, 2008, p. 744). In doing so, the authors argue that:

The notion of chaos operating in drug related discourse tends to...uncritically promote neo-liberal norms. (Fraser & Moore, 2008, p. 748)

Thus, drug users (or certain types of drug users) defined as chaotic are at odds with the neo-liberal order, where rationality and self-control are essential to constituting oneself as a self-governing citizen. In the same way, the non-agentive 'anxious', resistant', 'subsumed' and 'disgusting' methamphetamine-using bodies discussed above are dichotomous to those that are enacted through practices such as harm reduction, CBT and self-help. And yet, as I have argued earlier, drug users considered 'orderly' — these active, self-reflective methamphetamine-using subjects — are always at risk of lapsing into 'disorder'.

Methamphetamine, as it is currently inscribed, leads us to regard every user as having the potential to become as grotesque as the bodies evoked by *The Ice Age*.

## **Conclusion**

In Chapter 4 I argued that the drug methamphetamine is constituted in scientific texts as a hyper-stimulant — as toxic and destructive. In this chapter, I have built upon this argument and shown that methamphetamine bodies are enacted in extreme absolutes in authoritative texts. Methamphetamine-using subjects are materialised as specifically anxious, violent and chaotic and yet, paradoxically, these bodies are simultaneously enacted as specifically active drug users, able to be self-reflective and controlled. Foregrounding practice and asking what these bodies can do reveals that they have different capacities but are shaped by the same assumptions — the centring and valorisation of the agentive, knowing and self-controlled subject, the fear of methamphetamine itself and disgust at the addicted subject.

The binary opposition of drug-using bodies in the neo-liberal episteme has been previously elucidated in the literature (see, for example, Sedgwick, 1992). I have built upon these insights in this chapter by making visible the specificity of methamphetamine-using bodies and by tracing the connections that make this specificity possible. I have shown how the materiality of methamphetamine is inscribed as a particularly insidious drug; one that is highly addictive and, at times, compared to heroin in order to evoke its destructiveness. Thus, front-line worker manuals enact methamphetamine users as hyper-violent and toxic bodies and the media constitutes ice users as barely human. Yet, because of an absence of a pharmacological equivalent to OST and diagnostic tools that problematise particular practices and ways of thinking, we are able to simultaneously constitute methamphetamine users treatable via CBT and self-help — highly active and self-reflective forms of intervention.

In revealing the extreme absolutes of methamphetamine-using bodies, I have also illuminated the slippages and tensions involved in their enactment. Practices such as CBT and self-help enact methamphetamine-using subjects capable of self-reflection and self-control. These subjects, however, are always at risk of losing their volition due to the destructive and addictive properties attributed to methamphetamine. They then materialise as methamphetamine-using subjects that are resistant, anxious, paranoid and/or subsumed by the drug. These bodies are failed neo-liberal citizens. This shows the political nature of these bodies — that is, the choices, assumptions, contradictions and ‘conditions of possibility’ that shape these bodies. These bodies are not pre-existing, inevitable manifestations of

methamphetamine use. They are constituted through practices that are, in turn, shaped by the ways we think about drug use, unable to exercise self-control and, in the extreme, living on the margins of society.

The extreme absolutes of methamphetamine use are insufficiently complex ways of understanding drug use. Without diminishing the experiences of people who use methamphetamine and who find that it has harmful or negative effects on their lives, methamphetamine (and other drug) use is often for pleasure, and not unequivocally a dangerous and addictive practice. This is attested to by the significant proportion of the population who have used this drug yet suffered few problems. Further, in considering ways to reconceptualise or produce bodies that use this drug, it is helpful to move beyond neo-liberal assumptions that locate agency within the sovereign subject and considering drug use as solely an individual practice. Drug use is more productively thought of as an assemblage, where a confluence of objects (including the drug methamphetamine, syringes to inject or pipes to smoke), subjects (people using the drug, people selling the drug, treatment providers, police), spaces (a self-help website, a treatment service, a toilet in a nightclub where it is injected, but also the sounds, sights and sociality of these spaces), organisations (governments that make this drug illegal — yet also provide harm reduction information, a police force that enforce laws, the medical profession that define drug use as a pathological practice) and so on, come together to produce and re-produce drug use. Conceptualising drug use in this way de-centres the subject, showing the dynamic effect of all these phenomena in drug assemblages.

However, what does conceptualising methamphetamine use as an assemblage and subjectivity as fragmented mean for someone seeking treatment? For someone who considers themselves addicted to methamphetamine? For someone who has experienced psychosis when consuming methamphetamine? For someone who sells methamphetamine? For someone treating a person who uses methamphetamine? These are questions that I address in the following chapters, where I consider the accounts of people who consume methamphetamine, and people who treat methamphetamine consumption. In shifting to my empirical data, I illuminate the ontological politics of methamphetamine-using bodies. I show how hegemonic assumptions shape the day-to-day practices around consumption and treatment. At the same time, I show how these are resisted and subverted.

## Chapter 6: Consuming methamphetamine: Accounts of methamphetamine use

### Introduction

To this point, my thesis has addressed the enactment of methamphetamine and methamphetamine-using subjects in scientific, policy, treatment and media texts. In this chapter I move from these authoritative discourses to my interview data and how people who use methamphetamine constitute themselves. In Chapter 4 I argued that scientific discourse enacts methamphetamine as a specifically potent, addictive drug. In Chapter 5 I argued that policy, treatment and media documents materialise methamphetamine-using bodies in two spheres of absolutes: knowledgeable, self-controlled, reflective bodies and anxious, resistant, violent, toxic and chaotic bodies. Moreover, these are extreme absolutes; that is, despite the enactment of methamphetamine as a highly destructive substance, people who use methamphetamine can be constituted as highly functional, self-controlled individuals. At the same time, users are evoked in texts as uniquely toxic — violent and psychotic. While dualistic, these bodies have a common thread: the valorisation of the sovereign subject and its capacity to exercise choice and autonomy, and abhorrence of the addicted subject. I have argued that enacting methamphetamine-using subjects in these absolutes masks the assemblages of drug use, producing drug use as the act of a self-contained individual. This has the political effect of placing responsibility for drug use on individuals, legitimising them as objects of surveillance, blame and vilification.

I now shift from tracing the enactments of methamphetamine and methamphetamine users in authoritative texts to exposing how these may come to bear on the ways individuals who use methamphetamine constitute themselves. To explore the ontology of methamphetamine-using-bodies, I spotlight the relationship between the ways consumers embody themselves and the absolutes enacted by scientific, policy, treatment and media discourse, showing how hegemonic ideals are (re)produced and subverted in accounts of methamphetamine consumption. I also attend to the material—semiotic networks that constitute methamphetamine-using bodies, challenging the valorisation of choice and free will in the act of drug taking. I argue that individuals do not have inherent qualities but that these networks capacitate bodies in particular ways. Active practices and attributes such as self-control and the ability to make the ‘right’ choices are shaped by the social and material connections an individual is able to make. Likewise, feeling out-of-control or ‘taken over’ by

methamphetamine and other uncontrolled practices emerge from the relations an individual forms, and the assemblages they are enmeshed within, rather than a deficiency of will. I also show how methamphetamine-related practices are more complex than the absolutes that shape drug use allow, with individuals simultaneously understanding themselves as in control and addicted, as careful and hedonistic or as psychotic and reasonable. This is reflective of the complexity of drug use and of the multiple ways in which people incorporate broad understandings of drug use in their lives, both embracing and subverting these. By investigating the ontological politics at play in the constitution of methamphetamine-using bodies I study methamphetamine use as a matter of concern (Latour, 2004). That is, I recognise the inherently political nature of realities and, rather than seeking to reveal facts about methamphetamine use, show instead the complexity of drug use and the political effects of dominant ways in which we currently understand drug users.

### **Embodying multiple selves through practice**

To consider how methamphetamine consumption practices constitute particular bodies I draw upon the work of Mol and Law (2004), who argue that we ‘do’ our bodies through practice:

We all *have* and *are* a body. But there is a way out of this dichotomous twosome. As part of our daily practices, *we also do (our) bodies*. In practice we enact them. If the body we *have* is the one known by pathologists after our death, while the body we *are* is the one we know ourselves by being self-aware, then what about the body we *do*?

What can be found out and said about it? Is it possible to inquire into the body we *do*?

And what are the consequences if action is privileged over knowledge? (p. 45)

Mol and Law (2004) explore embodiment in the context of hyperglycaemia, a condition experienced by people with diabetes. They argue that in the current episteme there are two ways of knowing the body: ‘objective, expert, public’ knowledge, and ‘subjective, private and personal’ knowledge of the body from the inside (Mol & Law, 2004, p. 48). They find that attempts to address the dominance of expert public knowledge (see, for example, Sullivan, 1986) seek to integrate and extend personal knowledge, and thus the dichotomy between public and personal knowledge remains. To address the distinct knowledge domains of the public and the private, and to better comprehend embodiment, Mol and Law (2004) assert we must shift our focus from the accumulation of knowledge to the foregrounding of practice.

Mol and Law (2004) understand embodiment as dynamic. Like Buchanan (1997), they reject the idea of a pre-existing subject, considering the subject as continually made and re-made

through practice. Further, these scholars note that not all practices are possible — they are shaped by and emerge from the neo-liberal episteme. In addressing the subject as constituted through practice, these scholars draw upon the Deleuzian idea of becoming, where embodiment is always in flux and produced through multiple assemblages. In order to comprehend embodiment, the assemblages through which people ‘do’ themselves must be taken into account. This involves tracing myriad relations between human and non-human entities that produce, and are produced by, drugs, drug use and drug bodies. This way of thinking about embodiment has implications for how accounts of people using methamphetamine are addressed and allows me to explore the ontological politics of embodiment; that is, the open and contested nature of identity. The practices identified in accounts are thus considered in light of how they enact becoming ‘selves’, rather than as the symptomatic behaviours of an anterior pathological and/or deviant subject.

Attending to the connections and relations formed between human and non-human entities also allows me to show that these are productive of individual capacities and attributes. Using STS theorists, Duff (2012) argues that the relationships between things capacitate bodies and that shifting relationships result in differing bodily capacities:

agency is a function of the slow development of network relations such that each actor’s agentic capacities differ according to the character of these relations (Latour 2005: 63–65). While the development of novel associations necessarily transforms an actor’s specific capacities, such capacities are dependent on the ongoing maintenance of these relations. If relations are disrupted or suspended, if relationships break down or actants fail, then the actor’s individual capacities will also decline. Relations may, in this way, be described as conduits or mechanisms for the production, distribution and utilisation of agency (Law 2002). (p. 149)

Here, Duff is clear that capacity and agency are shaped and produced by the relations individual can form and to which they have access. Implicit in this argument is the assumption that individuals engage in an array of practices, and embodiment is multiple. These multiple selves are, of course, limited — they are more than one, but less than many (Law, 2004). They are always shaped by current conditions of possibility and the limited ways in which we can understand ourselves. At the same time, they are also capacitated by the localised assemblages they are enmeshed within and their connections to significant social and economic resources.

In this chapter, I move from scientific, policy, treatment and media discourses to my interview material in order to explore the ways in which the unique dualistic methamphetamine-using bodies enacted in authoritative texts shape accounts of methamphetamine consumption. I first discuss practices that produce drug ‘expertise’ and a high level of control in drug taking. I then examine the ways in which participants ‘do’ themselves as addicted and as taken over by methamphetamine, or driven by traumatic events. In doing so, I make visible the messiness and complexity of methamphetamine using practices arguing they emerge from material—semiotic networks, rather than a result of individual attributes. .

### **The neo-liberal subject? Expert, knowledgeable and self-controlled drug-using practices**

In this section I discuss the expert, knowledgeable and self-controlled methamphetamine-using practices identified in participant accounts. These are practices that materialise bodies that express the attributes and capacities of the neo-liberal citizen. These include making methamphetamine, researching and understanding methamphetamine both neurally and chemically, and ‘extreme’ methamphetamine use. To elaborate on these practices, a case study of ‘Wizman’, an ‘expert’ user, is presented. Following this case study, practices that involve research and ‘expert’ consumption of methamphetamine are discussed. Then, ‘extreme’ methamphetamine-using practices are addressed. Finally, I consider how methamphetamine consumption practices materialise through the multiple networks within which people are enmeshed.

#### **Wizman: An expert, self-controlled and addicted biocitizen**

Wizman,<sup>14</sup> a 22-year-old man from inner Melbourne, was employed casually at a call centre at the time of our interview. His account of methamphetamine consumption was shaped by neural and chemical understandings of the drug rather than being a strictly lay account of drug taking, and drew upon scientific discourse to explain his methamphetamine use and subsequent addiction. In this sense, Wizman was an expert methamphetamine user and the localised practices he engaged in — knowing methamphetamine both chemically and neurally, making methamphetamine and treating himself for addiction — were highly active. Yet he also drew upon broader narratives of addiction and decline. In this way his account both reproduced and challenged existing discourses.

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<sup>14</sup> Wizman was the pseudonym chosen by this particular interviewee.

Wizman positioned himself as an expert in the area of methamphetamine in the first text message he sent me:

Hi nichola [sic]... I'd like to assist you in your studies on speed/ice use in Australia. I have used extensively on and off and consider myself an expert on the matter. Feel free to contact me if youd [sic] like to meet up for a coffee and gain some insight.

Wizman reinforced his status as an expert early in our interview by informing me of the way in which methamphetamine worked neurally:

What happens when a human ingests meth is the meth molecule basically mimics the action of a neurotransmitter called dopamine in your brain, so dopamine is linked in normal behaviour to basically, to pleasure and to, what's the best way to describe it; it's basically the reinforcement molecule in your brain. So, in normal activity — eating good food, spending time with people you love, sex — all produce dopamine which produces this pleasure response, but then also links you into a pattern of behaviour.

Later, Wizman explained how he became addicted to methamphetamine use exclusively in neurobiological terms, saying that injecting methamphetamine (as he did) led to addiction more quickly than snorting or eating the drug:

Whenever dopamine is released in the brain it reinforces whatever behaviour has produced the dopamine. When you ingest methamphetamine and it mimics this action and you get a massive increase in the concentration of dopamine in your brain, it's like basically you're ingesting pure chemical reinforcements. So if you were to take the drug orally and have that, as I said, that slow gradient of increase of dopamine in the brain it's not as behaviour-reinforcing as having that spike that you get from smoking or injecting. So that's really, neurologically, where it comes down to.

These statements draw upon scientific explanations of the impact of methamphetamine on the brain. Moreover, in this statement, methamphetamine itself moves beyond a substance to become a 'pure chemical reinforcement'. Here, Wizman enacts the drug as wholly a neural phenomenon. In this sense Wizman embraces scientific discourse, using it to understand his experience of methamphetamine and to embody himself as a methamphetamine expert.

In addition to expertise in the area of neurochemistry, Wizman knew how to manufacture methamphetamine. At the age of 16, he had set up a small methamphetamine lab in his backyard. Then, by extracting pseudoephedrine from over-the-counter pharmaceuticals and



synthesising it with red phosphorous and iodine, he made methamphetamine powder (speed). Wizman kept this secret from his parents and manufactured and injected speed almost daily from the ages of 16 to 18, while attending school. Talking about this experience, Wizman stated that he was a very good chemist, but that ultimately manufacturing methamphetamine for his own use was ‘a bit of a pitfall’. Nonetheless, in addition to having a neurochemical understanding of himself, Wizman also had an expert understanding of how to manufacture the chemical methamphetamine. Through these practices, he enacts himself as a highly agentive, expert user.

Wizman relates practices whereby he embodies himself as an expert and active methamphetamine-using body — he makes the drug, injects it without harm and knows what is happening neurally when he uses it. Yet, he draws upon conventional tropes to understand his drug use. In his account, Wizman relates a narrative of addiction, denial and recovery, in his own words, a ‘cliché’. For instance, Wizman says he was in ‘denial’ about how his addiction to methamphetamine was damaging his life:

At the height of my addiction I was convinced that I didn’t have a problem at all and it was only when I stopped using for about a week or so and then my sort of neurochemistry came back to normal I realised how much I’d fucked up.

He also describes the grief that his methamphetamine use caused his parents, as well as the depression he experienced, saying:

I was basically, yeah, suicidal and then obviously I had to confess to my parents about everything that I’d been doing, and that destroyed them and so I fucked up the home and I felt as though I’d just gone to rock bottom, beyond the point of no return.

The narrative of hitting ‘rock bottom’ is one common to drug use accounts and a leitmotif of the twelve step movement. Wizman engages with this particular cliché, yet he does not completely embrace it. He draws upon the concept of addiction, but also clarifies that he is a person with the capacity to stop using drugs. He points out:

The interesting thing about me is I understand that a lot of people just simply cannot stop using hard drugs and I can see why, just because of the pleasure or the escapism or whatever but twice now, with heroin and with meth, I’ve just said to myself that’s the end of that, I’m not doing that anymore.

Wizman enacts his body here as self-controlled; he is able to stop using heroin and methamphetamine. He thus embodies himself as both able to make the right choices and as addicted, subverting the voluntariness/compulsive binary (Sedgwick, 1992).

Further, while Wizman employed the narrative of addiction, denial and decline, for the most part he saw his addiction in terms of his neurochemistry. He considered it as something he could address through research and taking supplements such as ‘omega three oils and tyrosine’. By enacting his addiction in this way, Wizman again subverts the conventional subjectivity of an addict, constituting himself as a biological citizen (Rose, 2002). He describes his depression (after he stopped taking methamphetamine) as solely related to his neurochemistry:

I wasn't unhappy because I had disrupted my family or abandoned my friends or neglected myself...I was depressed...just because I had caused a neurochemical imbalance in my brain. It didn't have anything to do with any other environmental effects. It was that I had strictly depleted the dopamine receptors in my brain and I'd down regulated them so they weren't fully functioning.

Wizman therefore rejects the assumption he should be remorseful about his behaviour as an addict. He enacts his depression as a result of his (damaged) brain chemistry. Later in the interview, Wizman clarified that feeling depressed was a mixture of the social ramifications of using speed heavily for two years in addition to neural depletion. Nevertheless, in terms of treating his addiction and depression, Wizman sought to restore his brain to a ‘natural state’. Thus his ‘recovery’ from methamphetamine addiction involved rebalancing his brain chemistry, rather than activities associated with an addiction narrative such as counselling or making amends to those he had wronged. These recovery activities were self-initiated — Wizman treated himself — further embodying himself as an expert in the area of methamphetamine use.

The ways in which Wizman draws upon scientific discourse and the idea that addiction is a neurological disorder in order to embody himself mirrors some of the insights offered by Kylie Valentine (2007) and Scott Vrecco (2006). Both scholars use Ian Hacking's (2002) theory of ‘making up’ people to explain how people draw upon broad discourses to understand themselves — to ‘make up’ themselves. Valentine (2007) points out that localised practices are also essential to understanding the ways that people embody themselves. Yet, at the same time, people employ broader cultural understandings around these practices to enact

themselves. In this case, the localised practices Wizman engages in are expert and self-controlled, but he is still compelled to draw upon meta-narratives of addiction to identify himself and understand his drug use.

Vrecko (2006) uses Hacking's work to assert that an effect of understanding addiction neurologically is that people can then embody themselves in less pejorative and limited ways. For instance, cravings to use alcohol or other drugs are evidence of being 'endorphin challenged' (Vrecko, 2006, p. 302), not proof that one is, and always will be, an addict. In Wizman's case, embracing a neural and chemical enactment of methamphetamine does two things. First, he establishes himself as an expert body, able to manufacture the drug and understand its effects. He also remains in control — attending school, keeping his activities secret from his parents and then making a choice not to use 'hard drugs'. These practices reject conventional understandings of drug-using bodies as compulsive and chaotic. Second, he provides a neurological explanation of his addiction and the subsequent restoration of his brain to its normal state. So while he uses an addict subjectivity to tell his story, he is also a biological citizen; he is both self-controlled and an addict. By embodying himself this way, Wizman subverts binaries such as voluntariness/compulsivity and controlled/chaotic that structure our understanding of addiction. Additionally, the figure of the addict contributes to Wizman's expertise, as he has actually experienced addiction as well as being a lay expert in the science of methamphetamine.

### **Knowledgeable and controlled practices: Researching methamphetamine**

Wizman offers a particularly intriguing account of expert methamphetamine consumption practices, but other participant accounts also provide examples of expert and knowledgeable practices involving this drug. Several participants had researched methamphetamine and other drugs extensively in order to ascertain their safety and find out how to get the most enjoyment out of them. This involved reviewing mainstream information such as scientific literature but also engaging in online illicit drug forums (such as *bluelight.ru*). James, a 20-year-old student, had been diagnosed with Attention Deficit Disorder (ADD). He had researched the pharmaceuticals that had been prescribed for his ADD and drew a parallel between this activity and taking methamphetamine:

It's the same for like taking drugs and stuff, I know it's like, there wasn't really a point where someone [said] like, 'Oh yeah, have this random substance', 'OK', it was

like I knew about it beforehand, I'd researched it beforehand and an opportunity came up and I was like either 'yes' or 'no'.

James suggests in the above quotation that it would be foolhardy of him to take an illicit drug (or even a licit drug) without having done background research. This knowledge then provides him with the capacity to decide whether he will consume a particular drug.

As a result of research into methamphetamine James concluded it was a useful stimulant. He said of his research outcomes:

Mostly it just sounded like super coffee [*laughs*]. That's the best way to put it...that's pretty much what it was for me.

In keeping with his opinion of methamphetamine as an ultra-effective stimulant, when describing his use of methamphetamine James mostly talked about its usefulness in keeping him alert. He found it essential, for instance, to cope with a job that required him to work night shifts:

when it got to night shifts I was like, 'this is ridiculous I can't do this'! And then I was like 'oh wait hang on, super coffee'. And then yeah, it worked quite well with shift work and I swear to God, like with the cycles that you keep, everyone there probably takes some sort of drugs to stay awake.

He also used methamphetamine to 'sober up' and stay out after drinking alcohol:

I'll go to a friend's house and we'll just be drinking all night and I'll be really drunk and then someone else will call me and be like 'hey, do you want to go out' and normally I'd go 'oh no, I'm just going to go home and go to bed' but if I've got speed or something, if I take that it'll just kind of balance me out so I'm not slurring, staggering drunk, but I'm still drunk and can go out, you know a bit more composed. So it works well for that too.

The practices of use that James recounts enact methamphetamine as a 'super coffee'; a substance that enables him to get through his night shift or to go out after drinking alcohol. Even though he uses methamphetamine to party, its function is to keep him composed. This practice is very similar to that noted in Pennay's (2013) research with young party drug users in Melbourne, who also consumed methamphetamine to stay in control.

For James, the decision to take drugs is the outcome of a rational process where he uses methamphetamine to stay in control and stay awake. Through these practices, James embodies himself as a knowledgeable and controlled user. His choices are informed by

rationality, rather than these choices being driven by desire, impulse or compulsion. Additionally, methamphetamine is enacted as a useful tool — ‘super coffee’ — a very different object to the toxic and addictive substance inscribed in mainstream scientific literature. While this might seem counterintuitive given that James researched methamphetamine previously, James was accessing websites where subversive discourses around drugs and drug use are found. Websites such as *blulight.ru* are frequented by expert drug users who challenge dominant discourse concerning drugs, but may also use scientific discourse to make their arguments (Barratt, Lenton, & Allen, 2013). Moreover, James was prescribed ADD medication (methylphenidate, marketed as Ritalin™) — a drug chemically similar to methamphetamine. He had therefore experienced using a stimulant for functionality and taking methamphetamine was perhaps simply an extension of this.

Claire, a 25-year-old student, also engaged in the practice of researching drugs before consuming them, but with a slightly different intent. She considered herself a studious nerd who wanted to experiment with drugs;

I was a nerd and I did a lot of study, I didn’t really party at all. And then I got curious. Prior to experimenting with drugs, Claire researched them in order to figure out which ones would be the most pleasurable:

I actually thought like if I tried any drug I just — I researched them all and I just — I ordered them, and I thought which ones I would enjoy the most.

Thus, Claire’s initiation to drug use was extremely controlled. She researched drugs to find out which ones she thought she would enjoy and procured these. While Claire, like James, engages in research prior to consuming drugs, she states that this practice is for subversive ends; to ‘party’ and to gain enjoyment. In this sense, while ostensibly responsible, this practice has multiple outcomes. Researching drugs in a controlled manner may produce safer drug use, but might also produce a better high and more pleasurable drug use. This is self-controlled, responsible practice with, at times, a hedonistic intent.

As expert and controlled users, James and Claire — like Wizman — draw on broader discourses of personal responsibility and the obligation to make the ‘right’ choices. They thus enact themselves as neo-liberal citizens. In this sense they disrupt the violent and chaotic methamphetamine-subjectivity enacted in the media and other discourses. As expert and knowledgeable drug users they reflect the methamphetamine-using bodies that are enacted through harm reduction, CBT and self-help practices. In Chapter 4, I argued that by

constituting rational, choice-making, drug-using bodies these practices obfuscate the lived experiences of people who use drugs and how their choice-making capacity may be constrained by drug-using environments. James and Claire's drug using practices illuminate how assemblages may also materialise knowledgeable and controlled drug-using bodies. These participants were both students, with access to and knowledge of resources such as computers, the internet and academic databases. Through these resources, relationships were formed with other people interested in methamphetamine (and other illicit drugs) and information was shared. These particular networks of actants (computers, the internet, drugs) and actors (other people interested in learning about drugs, and James and Claire who as students had research skills and an understanding of themselves as individuals capable of research and learning), created the possibility for active and controlled drug-using practices. James and Claire were able to embody themselves as knowledgeable and in-control drug users because of their relationship to machines such as computers and their familiarity with scientific literature and the internet. The connections they make with drugs are mediated through these 'things'; they are expert users.

### **'Excessive experience': Extreme drug taking**

The practice of 'extreme' drug taking was another way in which participants 'did' their bodies as expert and controlled methamphetamine users. Participant's accounts indicated the practice of 'extreme' drug taking was productive of a strong-minded subjectivity. Some participants talked about going on binges of methamphetamine and other drugs (particularly alcohol), and of pushing their mental and physical limitations during these binges. One participant, Paul, aged 20 and unemployed, describes a period where he consumed GHB and methamphetamine daily:

It was different yeah, full on.

#### **What do you mean full on?**

It was like on the edge, do you know what I mean? You could tell that you were pushing the limits sort of thing, yeah.

#### **How can you tell you're pushing the limits?**

I don't know. It's just; your body just starts to shut down, all sorts of things.

#### **What, you think you're about to collapse or something?**

Yeah.

#### **But do you feel good or?**

You do feel good, yeah.

Paul describes a fine line between his body shutting down and feeling good. He uses the phrase ‘pushing the limits’ to encapsulate what was happening when he took drugs in this way. This term is commonly used in association with individuals undertaking endurance or extreme sports, such as marathon running and big wave surfing. These individuals are typically viewed with a mix of admonishment and admiration: admonishment in that they put themselves at risk due to the fine line between their physical feats and serious injury or death, admiration in that they display qualities of fearlessness, strength of will and determination — qualities that are valorised in the neo-liberal episteme. In pushing his body as far as it can go, to the point that he risks collapse or his body shutting down, Paul enacts his body as expressing the hyper-agentive capacities of an endurance athlete, such as fearlessness and determination to go to ‘the edge’.

Andy, a 25-year-old builder, also described extreme drug-using practices. He related occasions where he consumed methamphetamine and other drugs for seven days without sleep, attending music festivals and hanging out at friends’ houses. Andy volunteered that he enjoyed the feeling of sleep deprivation as though it was another drug:

You just feel, you feel kind of good, like just really slow, kind of, I don’t know, sort of ‘erhh’, it’s like walking around, oh I can’t be fucked, you know, it takes you half an hour to get up a set of stairs but once you finally like get there, I dunno, it’s hard to explain.

Andy appears to embrace extreme sleep deprivation, a side effect of bingeing, to the point where it becomes an enjoyable part of the drug use experience. Andy commented that he had never hallucinated when experiencing sleep deprivation and said:

You’re on all kinds of other drugs so you don’t know, I haven’t gotten that far yet to hallucinate but just, I don’t know.

Through noting that he has not yet reached the stage where he might hallucinate, it seems getting to this point is a goal rather than something to be avoided. Thus, like Paul, Andy is interested in pushing himself to the limit — a valued attribute in mainstream society — through drug use.

Pursuing extreme drug taking has parallels with Slavin’s (2004a) research with gay men living in inner-city Sydney. Slavin (2004a) argued that his participants engaged in ‘excessive experience’ (p. 445) when taking methamphetamine and that this necessarily involved

breaching the boundaries of safe or acceptable drug use. Seeking excessive experience, and the risk it involved, was an intrinsic part of the pleasure of methamphetamine use. Likewise, Andy and Paul are seeking an experience beyond what most would consider safe or acceptable drug use. But for these participants this is part of the pleasure of drug use.

Extreme methamphetamine-using practices enabled participants to constitute themselves as strong-minded individuals. Andy considered extreme drug-using practices as only suitable for some individuals. He cautioned:

A lot of people can't handle it like, it all depends on the mind of the person, you know a lot of people aren't designed to take that much drugs.

Michael, a 27-year-old unemployed painter, gave an account of extreme methamphetamine use that, like Andy's, suggests only certain people have the capacity to undertake this type of use:

Over the years I learnt to control it, you know what I mean, and the gear [methamphetamine] back when I started was a lot stronger, a lot more potent than what it is now. And now like, me and my mates, like we just smoke [methamphetamine] flat out and it does nothing, we don't get the paranoia, we don't get the, it's more for your weak, narrow-minded people that turn like that. If you're easily influenced, you're weak-minded, like ice is not a drug for you because you're going to lose the plot and the paranoia is going to set in. And you're going to start doing stupid stuff, you know what I mean, being erratic and just out of control.

Michael is explicit that smoking a lot of methamphetamine is not for 'weak' people. Through engaging in the practice of smoking 'flat out', he enacts an active drug-using body that is in control and mentally strong enough not to 'lose the plot'. In this particular drug-using assemblage, Michael's body expresses its capacities through the substance methamphetamine, embracing its material effects — such as wakefulness and its ability to combine with other drugs. It also demonstrates particular attributes, such as strength of character, through overcoming, or controlling, these effects. In this assemblage, ice is enacted as a potentially dangerous drug, requiring a strong mind to control it.

The practices described above involve the ability to master and control methamphetamine. They allow participants to embody themselves as individuals with strong minds and high levels of endurance, qualities typically expressed in endurance bodies and elite sport bodies and thought to be absent in drug bodies. As discussed in Chapter Two, Kate Sear and



Suzanne Fraser (2010a) provide a case study of the elite athlete Ben Cousins (a self-acknowledged methamphetamine addict) in order to problematise the voluntariness/compulsivity binary. Through Cousins's account of how he understands himself, his methamphetamine use and his athleticism, Seear and Fraser (2010a) interrogate this binary, arguing the two concepts are not exclusive with Cousins considering aspects of his practice as an athlete compulsive. They find that:

For Cousins, the 'truth' of himself is that he is both compulsive and voluntaristic, with each reliant upon the other for its existence (Seear & Fraser, 2010a, p. 449).

The extreme practices of methamphetamine use described above reflect this point, even without participants engaging in other practices characterised by high levels of voluntariness. Paul, Andy and Michael engaged in what they considered a compulsive activity (consuming methamphetamine), with Andy considering himself as having an 'addictive personality'. Yet, the drug-taking practices they related enact them as simultaneously driven to take the drug, but also with the requisite physical and mental strength to push themselves to the limit, remaining in control of effects such as paranoia. In this way they embodied themselves as both compulsive and voluntaristic. While the insight offered by Seear and Fraser (2010a) is that compulsivity was integral to Cousins's practice as a professional athlete, the participants in my research illustrate that the practice of methamphetamine use itself can involve high levels of voluntariness, while at the same time involving elements of compulsion. These practices demonstrate that drug use is more complex than the voluntariness/compulsivity binary allows.

### **Patterns in expert, knowledgeable and controlled practices of methamphetamine consumption**

To this point I have discussed some of the expert, knowledgeable and controlled practices in participant accounts, including neural and chemical understandings of methamphetamine, researching methamphetamine and extreme methamphetamine use, showing how these practices both draw upon and subvert dichotomies that underpin drug use — such as controlled/chaotic and voluntariness/compulsivity. I have also aimed to illustrate some of the ways these practices are produced through material—semiotic networks, rather than being driven by the inherent characteristics of particular individuals. Building upon this particular insight, I now discuss commonality among participants whose accounts featured knowledgeable and controlled methamphetamine consumption practices. These participants tended to have strong connections and relationships to social resources (such as family

support), economic resources (such as a steady income, home ownership) and educational resources (for instance, some were undertaking or had been awarded a university degree). This is not to say that those people without access to these resources did not think of themselves as agents or engage in knowledgeable and controlled practices (as demonstrated by Michael and Paul, both of whom were unemployed and had limited formal education). Broadly, however, they were less likely to have access to resources that enabled them to constitute themselves as self-controlled agents with a significant degree of power and control in their lives. These resources were linked to, and productive of, other identities that are typically considered to have a strong degree of responsibility and self-control such as 'professional', 'student', 'parent' and 'middle-class'. I argue that managing these multiple identities and their obligations, as well as the responsibility and power that these identities enacted, contributed to more controlled drug-using practices. In this section, I use the accounts of two participants to illustrate these arguments.

Kelly, aged 26, was a professional and the mother of Ben, a four-year-old boy. She injected methamphetamine almost daily. In the past, Kelly had been an active member of the dance scene and had engaged in extreme drug use, but her drug consumption practices had changed over time. Kelly had to use drugs very discreetly because of her identity as a professional and a mother. She hid her use from her parents, her son and the families she came into regular contact with due to her son's attendance at pre-school. She also hid her use from her employer knowing that she would lose her position immediately if her methamphetamine use came to light. Consequently, Kelly mostly used methamphetamine at home with her partner. A night of methamphetamine consumption would often involve a mundane activity such as watching television. She also used methamphetamine during the day but never enough so that it was obvious she was drug-affected.

Kelly's account suggests that managing her various selves has shaped her practices of methamphetamine consumption, shifting from binge use and partying to using in a more discrete, measured way. Having to change and conceal her methamphetamine use had both negative and positive effects for Kelly. A negative effect was that she knew if her drug use was discovered she would be judged on that practice above any other activity she took part in:

Yeah, that is the main negative for me is um, well you know, it's all of the good things that I do in my life, I feel if anyone knew about this part of my life I would be

judged on this more or above anything else that I do and like no one knows I do this, you know. It's a very private thing.

Here, Kelly feels that it is unfair her methamphetamine use could obscure all the other 'good' she did in her life. It is evident that for Kelly, this possible judgement is the worst thing about using methamphetamine. This particular insight makes visible the political effects of inscribing methamphetamine as a highly addictive drug and users as chaotic and violent. Kelly is more worried about the social harm she would experience if she were to be discovered, rather than the purported physical or psychological harms found in scientific discourse. In this sense her account also provides a subversive alternative to scientific discourse, as she fails to mention any significant negatives to methamphetamine use apart from the social consequences. That is, she is not primarily concerned with the toxicity and addictiveness of methamphetamine but with being 'found out'.

Yet, while Kelly found it 'negative' that her methamphetamine use jeopardised her multiple selves, she was clear that her roles as a mother and professional had changed the way she used methamphetamine in a positive way:

I mean back then I didn't care what anyone thought about me and I was young and I was free and I didn't have Ben... I didn't care if I wouldn't go home for three weeks... I'd leave and say 'I'll see you tonight' and I wouldn't go home for three weeks and I was being really irresponsible and stupid. But now I'm older and I do care what people think about me and I have responsibilities and a family and a child and bills and... a job and just responsibilities that I didn't have back then...if I acted that way now, I just wouldn't let myself, I just couldn't let myself act like that because...I'm walking a different walk.

**If you hadn't have had Ben would you still be doing that?**

No I'd probably be dead.

**Really?**

I don't know. Maybe. I don't know where I'd be if I didn't have Ben. Honestly I don't.

Kelly's account illustrates how the obligations of her multiple selves enact the way she used drugs with various effects. Her multiple selves meant that her methamphetamine use was a lot more stressful than in the past, primarily due to fear of discovery and threat it posed to her

other identities. However, at the same time, her identities as an employee and parent enabled Kelly to curtail her drug use and to use in a way she considered less harmful. Kelly's account also shows how changing drug use practices are driven by the localised networks drug-using bodies are entangled within. Kelly's increasing responsibilities, her professional peers and her family were part of the material—semiotic networks that produced a change in the way she consumed drugs, rather than this change being driven entirely by Kelly's willpower or the drug 'methamphetamine'. Moreover, these networks contributed to a sense of self-control, illustrated by Kelly stating that she 'couldn't let myself act like that' referring to ways in the past that she had used drugs. But as well as enacting herself through localised practices, Kelly also draws upon broad cultural narratives concerning gender and motherhood (valentine, 2007). As a mother it is unacceptable that she uses a drug such as methamphetamine and this has also shaped her changing drug practices. Thus, due to her multiple selves — enacted within localised assemblages and through drawing on broader understandings of the self — Kelly experienced a sense of self-control over her drug use.

Likewise, Gordon, a 31-year-old professional who worked in finance markets, also described the way his multiple selves shaped his methamphetamine use. Gordon enacted his body as an extreme drug user, on occasions taking methamphetamine all weekend. For instance, he described a period over a Friday and Saturday night as follows:

[I] got a couple of grams and had... three or four hours on the pipe... I came home, went to a friend's house, maybe two pm on the Friday, smoked some more speed with maybe four people there, someone's... birthday. Um, smoking joints, took some MDMA pills, had a trip,<sup>15</sup> bit more speed and then like, then the trip just kicked in, so it was sort of, you know, headlights for about six to eight hours, and then it was probably three, four am, pretty much run out of all our drugs.

During the week, however, Gordon worked in money markets, sometimes taking methamphetamine to fulfil that role but in a manner so as not to appear drug-affected. He described his use at work in the following statement:

If I've had a big night the night before or something, and you're hung over as all buggery, just a quick hit will straighten you out, or you've been up all night studying and haven't had any, and you wake up and you're still tired... you might just have a little, like just a little snort or something, just to get you up and ready, sort of thing.

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<sup>15</sup> A 'trip' is a colloquial term for a hallucinogenic drug.

Here Gordon describes a very different practice, one through which he enacts himself as a capable ‘work body’. Gordon was also a member of an amateur sports team who played at a reasonably high level. Again, sometimes he took methamphetamine to help him get through practice, similar to the way he might take methamphetamine prior to work. Thus while Gordon did not delineate his actual methamphetamine consumption — taking this drug socially, for work and for sport — he did delineate his practices of consumption, ‘doing’ himself as an extreme drug using body or work or sport body where appropriate. Within these shifting assemblages, Gordon constitutes himself in different ways and methamphetamine is also enacted in multiple ways. Its materiality is shaped through Gordon’s work, sport and social assemblages, expressive of a range of capacities, including competency and professionalism in the case of a work body, energy and physicality in the case of a sport body and intoxication in the case of a party body.

Like Kelly, the multiple ways Gordon constituted himself had both positive and negative effects on how he understood his methamphetamine use. Gordon was very conscious of the consequences for his professional standing if he was caught consuming methamphetamine or other illicit drugs, yet this concern was not straightforward. He talked about waiting nervously at dealers’ houses for methamphetamine or cocaine to arrive and being very aware of the other people he was waiting with:

These other guys who have probably been in jail before, have been through the system and some of them don’t even work and stuff, so what do you do? Like, if the police knocked on my door and said, ‘We’re going to tell your employer that we’ve found you with two grams.’ Like, you’d have to weigh up pretty quickly what you wanted to do.

Gordon worried that the police would be able to force him to reveal his dealers if he was caught, as he felt he had more to lose than people who did not have jobs and had already done time. Yet, while his identity as a professional caused Gordon to worry about ramifications of his use, it also made his use more exciting. He stated:

Yeah, bit of a buzzer...getting it for your mates. Like there’s that ego thing as well. Like you’re the guy that everyone comes to....certainly there’s an ego element to it. And you’re driving around with an ounce...in your glove box, or something, and it’s...miles away from my other world...that I’m in, that professional, clean cut, you know, business, sort of world.

Thus, while a threat to his ‘straight’ identity as a professional, Gordon found the practice of methamphetamine use, and buying and selling other illicit drugs (such as cocaine), was also enhanced because of this identity. These practices gave Gordon kudos as ‘the guy that everyone comes to’ as well as a thrill because, in his ‘clean cut’ world, they are extremely transgressive.

Kelly and Gordon’s accounts are illustrative of the ways in which methamphetamine use is produced by, and produces, the many ways individuals constitute themselves. The multiple selves of these participants required them to consume methamphetamine in certain ways and in certain environments. Their professional identities gave both Kelly and Gordon the money to use methamphetamine without the need to resort to criminal activity (although Gordon did occasionally deal cocaine to friends), but also obliged them to exercise considerable control over when and how they used methamphetamine. Their accounts illustrate how multiple selves are entangled, and how particular subjectivities may oblige some individuals, more so than others, to hide their methamphetamine use.

Participants engaged in a range of knowledgeable and controlled using practices, enacting methamphetamine-using bodies with the capacity to make choices and exercise volition. Examining these practices, and the assemblages of which they are part, suggest that participants both reproduced and subverted the dualistic ways in which drug users are enacted. Participants engaged in highly controlled practices (such as making methamphetamine and conducting research before drug use) not always to avoid harm, but sometimes to increase the pleasure of undertaking drug use. Extreme drug users pushed their body to the limit through consuming large amounts of methamphetamine for a long time, ‘doing’ bodies with capacities such as self-determination and fearlessness, attributes highly valued in wider society. Moreover, engaging in knowledgeable and controlled practices did not exclude participants from considering their methamphetamine use as compulsive or themselves as being addicted or having addictive personalities. Thus, compulsive practices and a sense of agency — the voluntariness/compulsivity binary (Sedgwick, 1992) — were simultaneously evoked through the practice of methamphetamine consumption.

Further, attending to the networks that produce drug use reveal the ways practice is shaped by assemblages of material, social and spatial resources and how bodies are capacitated within these assemblages. In the case of knowledgeable and controlled methamphetamine consumption, these assemblages included access to computers and the internet, research

skills, a professional career and corresponding income, and family support. Thus, self-controlled practices were made possible through particular relationships and connections between drug-using subjects, and their relationships and connections with certain environments, objects and subjects. Assemblage thinking shows how agency is facilitated by and dispersed within these assemblages rather than driven by the self-contained agentive subject, and that subjects are capacitated by the objects and environments with which they are able to make connections (Duff, 2014; Fraser, 2004). Moreover, methamphetamine use is more complex when examined in light of the way individuals manage multiple selves. It was evident from participant accounts that the various networks and connections in which people were enmeshed were productive of self-control and obliged them to make the ‘right’ choices and thus to manage their drug use in particular ways.

### **Uncontrolled methamphetamine consumption practices**

In addition to practices that enacted knowledgeable and controlled bodies, participants described practices of methamphetamine consumption that were less controlled.

Methamphetamine is enacted in scientific discourse as an addictive drug. Thus, consumption of this drug is considered a compulsive activity, where the properties of methamphetamine are considered to drive people to use again and again. The drug-using body with compromised agency is therefore a familiar one, and one that was often evoked in participants’ accounts. In these cases, subjects ceded their power or choice-making capacity to their addictive personality, trauma or the drug methamphetamine itself. I now describe and discuss some of these practices evident in participant accounts. In doing so, I move beyond accounts of drug use that centre on the addicted and compulsive subject. Instead, I show how practices that evoke a lack of control or choice-making are produced through material—semiotic networks, rather than as a result of an individual’s lack of willpower. Similar to expert, knowledgeable and self-controlled practices, I also show how the concepts of self-control and choice are messy and not easily delineated from their binary opposites. The practices explored are: knowing oneself as an addict, being ‘taken over’ by methamphetamine and linking trauma to the use of methamphetamine. I also describe a participant’s experience of methamphetamine-induced psychosis to show the complexity of this state in terms of ‘self-control’.

#### **‘I’ve got an addictive personality’**

Most of the accounts of participants in this research featured the concept of addiction, and many readily ceded agency to the substance ‘methamphetamine’. Most participants said that

they felt compelled to use the drug and saw themselves as addicted to it or as having an addictive personality. For instance, William, a 42-year-old unemployed truck driver, considered himself addicted to methamphetamine:

You could smash something and you know, it depends on how you feel, because you've got to have it. And that's how I consider being an addict, if you can't go without it, you know, no matter what it is; whether it's alcohol, drugs, you smoke, you know. If you cannot go without it, and if you're having this problem, you know, every single day, that's how I consider an addict, which I considered myself as, because I couldn't go a day without it.

Here, William describes himself as an addict as he needed to take methamphetamine daily. Further, he implies a violent reaction if he is unable to get the drugs he needs. He thus enacts his body as having limited capacity to exercise free choice. He acts in order to consume drugs and may become violent if he cannot.

Madison, a 25-year-old hairdresser, did not consider herself addicted to methamphetamine but still saw herself as without control when it came to taking this particular drug because of her 'addictive personality':

If someone put it [methamphetamine] in front of me, then it's, like, you know, 'Do you want some of this?' I've got an addictive personality, so if someone goes, 'Do you want some?' I'd be, like, 'Yes.'

Andy also reported having addictive personality. He said:

I think the people who take drugs are people who have like a certain personality, like an addictive personality, so no matter what they're going to get addicted. You know like, it's basically, if someone, it's like me, like I didn't really want to get into speed at all, I don't even like the drug but for some reason I just can't stop smoking pipes and now...I really don't even like it that much.

By constituting themselves as having addictive personalities, Madison and Andy effectively relinquish their volition with regards to taking any drug or other compulsive practices; an addictive personality means one has the potential to be addicted to anything. Moreover, Andy suggests that an addictive personality can compel one to engage in practices one does not even enjoy.

As I have noted, a lack of volition is a feature of the way in which drug use and drug users are enacted within the neo-liberal episteme (Sedgwick, 1992). Without wishing to dispute the



accounts offered by participants, or negate the feelings of compulsion they may have experienced, addiction and addictive personalities are very readily available yet simplistic explanations of more complex desires and situations. The dominance of the voluntariness/compulsivity binary does not offer people who use drugs the opportunity to consider their use in a more nuanced way. If there was greater recognition of alternative and more sophisticated ways of understanding drug use, such as those offered by Helen Keane (2002, p. 35) and Kate Seear and Suzanne Fraser (2010a, p. 450) it is possible that individuals might embody themselves without drawing on the absolutism that underlies dominant drugs discourse.

### **'I thought I was King Kong': Taken over by methamphetamine**

While some participants felt they were powerless over methamphetamine because of personal attributes (such as having an addictive personality), others felt powerless over methamphetamine due to the properties of methamphetamine itself. Several participants suggested that they felt as though methamphetamine controlled them, taking away their ability to exercise volition as they normally would. For these people, the practice of consuming methamphetamine led to the embodiment of a different and in some cases inauthentic self. For instance, Sebastian, a 30-year-old student, found that once he started taking methamphetamine his priorities would change without him even realising it. He stated that he had recently taken some speed over his university break:

I had some speed [methamphetamine] and, over like this...like a break, and then because it's your whole mental state, I guess, your priorities, everything just as soon as you have it changes without you sort of noticing that shift and...things will go...out of control really quick.

In this instance Sebastian went back to university after the break, but related the above incident as an example of how easily his life could get 'off track'. Sebastian found that the practice of consuming methamphetamine led to a 'mental shift', leading to things becoming 'out of control'.

While Sebastian attributes his mental shift entirely to methamphetamine use, examining the various networks that produced Sebastian's drug use enables other interpretations of this shift. Sebastian lived with two fellow students in a very run-down house, with little in the way of study resources. He had no desk or study space and only a mattress on the floor in his bedroom. The house he lived in was located next to a government housing estate with an

established illicit drug market. Sebastian had taken both methamphetamine and heroin for over 10 years. He was prescribed Xanax<sup>®</sup>, a benzodiazepine, which he often sold in order to supplement his student benefit. He had only recently enrolled in university (for the first time) in his late 20s. The networks within which Sebastian was enmeshed — the immediacy of the illicit drug scene, his unfamiliarity with study, the lack of study resources in his home environment and his precarious financial situation, produced tenuous links to his university existence and were also productive of ‘out of control’ practices such as getting ‘off track’. So while Sebastian considered himself as driven by methamphetamine use — without at times even noticing — it is possible to offer alternative accounts of his use. These might consider how his fragile connection to basic student resources also shaped his actions.

Like Sebastian, Ross, aged 38 and on a disability support pension, gave an account of methamphetamine consumption that featured uncontrolled practices, during which he felt taken over by the drug. Ross described himself as a ‘standover man’, explaining that he would go to houses where he knew the occupants had alcohol and other drugs and through threat and intimidation take their ‘stash’. He said that he was able to do this because he became a different person ‘on the ice’:

I just, it just made me become that person, the ice. Before that I was never like that.

Ross’s ice body was ‘invincible’, with the capacity to demand and take what it wanted:

The ice made me feel like I was invincible, so mixed with alcohol I thought I was King Kong, I just demanded their drugs off them and most people would hand it over because they didn’t want the conflict.

Although Ross engaged in a practice that was highly aggressive — seeking out people with alcohol and other drugs and standing over them — he ceded his choice-making to ice. This drug was the agentive force within his ice body. Ross’s actions were not admirable by any means, as he himself noted. Locating the source of these actions in the properties of drugs, particularly ice, helped Ross to tell a story of his drug use in which he was not a villain, without obscuring or hiding the unpleasant practices he undertook to obtain the drug.

Ross, like Sebastian, was an individual with limited access to material, economic or social resources. While his practice of ‘standing over’ people was highly unethical and unlikeable, he had few relationships and connections that availed him of alternative ways to procure drugs. Whereas participants such as Kelly and Gordon had incomes which allowed them to

pay for drugs, Ross had very limited income. As he explained, this contributed to his becoming a standover person:

I grew up in West Heidelberg so I sort of like become sort of like a standover person...Somebody that goes in to somebody else's house and tells them to give me their drugs and stuff like that because I couldn't afford them.

Here Ross links both the environment of West Heidelberg — a Melbourne suburb characterised by high-density government housing and people living on low incomes and government benefits — and his lack of income with becoming a standover person. Later in the interview it became apparent that violence was common to the many assemblages Ross was enmeshed within. His father had been violent to him as a child; the people he grew up with were 'gangsters'. Ross was also homeless and had few friends. He had very little contact with his family, saying that 'they won't even come and bring me a packet of smokes'. This is not to excuse the violent and objectionable practice of standing over people, but to demonstrate how the resources one is connected to can produce particular types of drug use. The material—semiotic networks within which Ross was enmeshed were embedded within an environment where violence was not uncommon and which was characterised by a general lack of basic resources. This contributed to the materialisation of an ice body with the capacity for violence and intimidation.

### **'I've never really lived in society': How trauma shapes drug use**

Participants also constituted themselves as driven to take methamphetamine through the concept of trauma. Trauma is commonly linked to drug use, with a significant amount of research attributing and/or linking the experience of trauma to drug use (see, for example, Jacobsen, Southwick, & Kosten, 2001; Messina et al., 2008; Reed, Anthony, & Breslau, 2007; Stewart, 1996). In this body of literature, trauma and traumatic events are sometimes used to serve as explanations for drug use — and lay understandings of this condition may (re)produce this linkage (Hacking, 2002). Thus, it is not surprising that participants in my research often linked trauma to drug use. In these cases, the experience of traumatic events was thought to render an individual more susceptible to problematic drug use. In this section I address accounts of trauma, looking at the ways in which the understanding of trauma shapes drug use practice.

Kate, aged 39 and parenting a young son, directly attributed her methamphetamine use to a traumatic event. Kate and her son lived in 'the walk ups', state housing accommodation

within a larger state housing estate. Kate was ‘bashed’ (physically assaulted) one night by a female neighbour and as a result found she could not sleep without nightmares. Because of this, Kate had begun taking methamphetamine — mostly in the form of ice — to avoid sleep. She explained:

I tried the ice six months ago. I was on the amphetamines, I got assaulted with an iron bar in my own car park, I live in the walk ups.... I got attacked by a steel bar by a ...girl who was very filled up in tablets, Xanax. Um, she bashed me with the iron bar, I’ve got 12 slashes down my legs, all bruised, my elbow popped out...

**So you were really stressed after it?**

Oh yeah and to this day I have put an intervention order on her, done everything that’s supposed to be possibly have to be done um ...Now because I couldn’t sleep, I did sleep but not all night, I kept having bad nightmares about reoccurrence of what’s happened to me...I couldn’t sleep so I got addicted to the ice.

Kate clarified her methamphetamine use was not to experience a high but just to stay awake. She said:

It was more of a booster, not to go to sleep; just it was trying to make me stay awake so I can stay awake and not have any more nightmares.

She also explained that it helped her manage having to face her assailant:

It [ice] blocks out a lot of problems for me. If the girl went past me and I was on ice I wouldn’t shiver or shake or anything like that.

Kate had experienced a violent and distressing event, particularly disquieting as it had happened in the immediate vicinity of her home. In her account, this event is the root cause of her problematic methamphetamine use — use that had resulted in her having to go to a ‘detox’.

Kate enacts herself as a body with reduced capacities due to a traumatic event. In her account, it is not her choice to take methamphetamine; rather, she is compelled to take it to stay awake in order to manage the trauma she has experienced. Furthermore, she enacts methamphetamine as a substance that gives her the capacity to manage her trauma. Its properties allow her to stay awake and give her the courage to face her assailant. Methamphetamine enables her to redefine her traumatised self as a controlled and strong person. Her drug-using assemblage — ice, traumatised body, small living space close to

assailant, young son, motherhood — constitutes methamphetamine as a drug that allows her to be in control and manage a situation in which she has little power or choice. In this way, Kate's account subverts traumatic discourse, where victims of trauma self-medicate. She is not using methamphetamine to forget her trauma, but rather to capacitate her traumatised body and manage her circumstances. That said, Kate also draws upon a self-medication narrative, explaining that taking methamphetamine allows her to 'block out' problems. Thus, her enactment of the concept of trauma in relation to her drug use is messy, both subverting and embracing dominant understandings of this concept.

There is no question that Kate's experience of being severely physically assaulted was horrific, leaving her feeling scared and vulnerable in her own home. However, while Kate uses the narrative of trauma to explain the drivers of her methamphetamine use, other relationships and connections shape her drug consumption. Kate identified strongly as a mother, stating 'I'm a mother' when asked what she did for a living. She lived with her youngest son who was attending pre-school. However, ten years previously, when she had been using heroin heavily, she had lost custody of an older son and daughter. The relationships Kate has with various institutions such as Centrelink<sup>16</sup> and child protection services, and her identity as a mother, are important when considering her particular account of drug use. She does not consume methamphetamine for pleasure (a selfish practice) but to self-medicate and stay awake due to the aftermath of a traumatic event. This enables her to manage her day-to-day life, including her responsibilities as a mother. By enacting her choice-making capacity as constrained by a traumatic event, Kate protects her identity as a mother, a very necessary practice in her case as she has previously been scrutinised and found to be lacking in this role.

Ross was another participant who linked his methamphetamine consumption to traumatic events — in his case a traumatic childhood. He explained that he experienced a violent upbringing and that this led to his drug consumption:

I've been taking drugs, like I said, for 28 years nearly, one drug or another, I think. In them 28 years I've only had, like, 12 months clean and yeah, once I took the ice, it was like again, it made me feel invincible; it made me forget what had happened to me. 'Cause like the first 10 years of my life my father used to bash us with pool cues, broom sticks, you name it, whatever you can think of, that's what my old man had

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<sup>16</sup> Centrelink is the Australian government body that distributes welfare payments.

done to us. So yeah, whatever I could do to escape that, because I never learnt how to deal with it, only way was to take drugs. So I seem to have gone from one drug to another drug to another drug, to three different drugs to just continuous, just yeah. I found it very hard and I'm finding it hard now because I've never lived, I've never really lived in society, in reality, I've always just existed, I've never really lived it.

Ross's experience of parental violence has powerfully affected the way he understands himself as an adult. He suggests that not having 'dealt' with this violence is the root cause of his drug use. But more disturbingly, he says that he has never had access to, or felt he has lived in, the 'real' world. Ross did not clarify what he meant by reality, but possibly he means that he has never had access to participation in the mainstream world, because of lack of the basic requirements to do this, such as paid employment, somewhere to live and a supportive family.

Ross also saw value in sharing his experiences. Towards the end of his interview after I thanked him for his time, Ross replied:

That's all right, it's going to help me to recover so you know, the more I release some of the crap that I've been through I think the easier I'll be able to get, get on with my life.

Here, Ross considers being able to talk about his past as a form of release that is part of the recovery process. This is reflective of Nikolas Rose's (1999) argument that public 'confession' from survivors of trauma has become integral to subjectivity. He asserts that the 'speaking out' of one's hidden hurts is considered therapeutically valuable and part of the ongoing process of uncovering one's authentic self (Rose, 1999, p. 269). Ross embraces these assumptions in his account where he implies that, through the confession of traumatic events, he will address the problematic and self-destructive practices in which he engages. Yet, it is apparent that these practices are produced through the particular assemblages within which Ross is enmeshed. These are assemblages that have tenuous, if any, connections, to the mainstream. The assumption that talking about his past is therapeutic and will help him 'get on' with his life may obscure what Ross lacks — meaningful connections to education, employment and social support.

Kate and Ross's accounts of trauma are further illuminated by Ian Hacking's (2002) assessment of this concept and the way in which it shapes embodiment. He argues that trauma is used to categorise people with the outcome of creating 'victims':

Traumatology has become the science of the troubled soul, with victimology one of its bitter fruits. (Hacking, 2002, p. 18)

Here, Hacking posits that the diagnosis of trauma has become the standard way to understand those experiencing psychological distress. Hacking (2002) has concerns about the ways trauma ‘figures in the constitution of selves’ (p. 19), arguing that once labelled as traumatised ‘the person is known about as having a kind of behaviour and sense of self that is produced by psychic trauma’ (Hacking, 2002, p. 19). Being in possession of traumatic memories creates a ‘new moral being’ as the experience of trauma can be used to explain current actions and behaviour (Hacking, 2002, p. 20). Thus, the traumatised subject is unable to exercise sufficient control and make the right choices due to their embodiment of traumatic events. In the case of both Kate and Ross, understanding themselves as victims of trauma provides a narrative to explain their methamphetamine use. Yet, it may other the complex and multiple assemblages they are enmeshed within, and how these constitute other selves. These selves — a mother or an individual who has never lived in ‘reality’ — also shape the practices of methamphetamine use.

Valentine and Fraser (2008) also add insight to the issue of trauma, specifically in relation to drug use. These scholars examine conventional understandings of problematic drug use as both socially mediated and associated with deprivation. While noting that the research that produces these understandings is valuable in many ways, these scholars argue it can be problematic. For instance, they suggest:

Associating problematic drug use with trauma and a fractured self can easily shift to a reinscription of users as deficient; where problematic drug use represents proof of trauma and nothing else. (valentine & Fraser, 2008, p. 411)

Moreover, they claim that defining drug use as inevitability linked to trauma risks denying people who use drugs the capacity for pleasure. In turn this could rob drug users of:

their capacity to narrate their own accounts of how and why they use drugs, and to present alternative narratives to those of science, treatment professionals, and their friends. (valentine & Fraser, 2008, pp. 415-416)

Kate and Ross embraced the concept of trauma, explaining their drug use in these terms. And yet, in other ways their accounts subvert the idea that drug use is about self-medicating to deal with trauma, with both participants taking methamphetamine to capacitate themselves: Kate as wakeful and alert, and Ross as threatening and a standover man. Thus, trauma does to

some extent limit the capacity of these individuals to ‘narrate their own accounts’. However, by subverting this concept, they also provide an alternative and more complex account of this concept’s relationship to drug use.

A final point to make about uncontrolled methamphetamine consumption practices is that there were common features among participants whose accounts featured these practices. Generally, participants who described uncontrolled drug use practices, such as feeling compelled to take drugs and taken over by drugs, were recruited from an inpatient detox treatment service. As a group, these participants typically had long histories of heavy drug use. Most were unemployed, had limited education, and a relatively high level of state involvement in their lives such as child protection services, parole requirements, law enforcement, and state pensions and allowances. As I have argued above, in the case of participants such as Kate and Ross, the networks in which they are enmeshed typically enact constrained power and choice-making capacity, and express the lived effects of poverty and social exclusion. Both of these individuals also had significant experiences of violence. Kate, for instance, was living very near a person who had assaulted her; this was highly undesirable but she was unable to convince the Department of Housing to move her. She was reliant on this particular agency for housing and unable to relocate herself because she did not have the economic means to do so. Her multiple selves — a single mother, a beneficiary of the single parent payment, a state housing tenant — enacted through the assemblages she was enmeshed within, had limited choice-making capacity and power. Kate considered her drug use as driven by trauma rather than her own volition. Given she lacked the resources that produce legitimate forms of power in Western liberal societies, such as education, income and housing, it is not surprising she might cede her agency to trauma or to the drug methamphetamine itself.

### **Psychosis – a controllable state of non-control?**

In this final section, I address the ‘uncontrolled’ state of psychosis in accounts of methamphetamine consumption. I discuss psychosis in relation to the concept of control primarily to illustrate that, in terms of drug use, it is messier than scientific discourse allows. Here, I build upon the work of Robyn Dwyer and David Moore (2013) who have also made this observation. Methamphetamine use is inextricably linked with psychosis and a large body of scientific research identifies and reproduces this link (see, for example, McKetin et al., 2006b). Yet, despite this body of literature, and the assumption in broader discourse that methamphetamine causes and/or is related to psychosis, few participants in this research had



experienced it. One participant, however, had experienced psychosis. Her account illustrates how terrifying the experience of psychosis can be. It also describes the ways in which she managed and ‘controlled’ psychosis.

Margot, aged 32, was a student living at home with her parents. She was a former heroin user, who had used amphetamine sulphate ‘back in the day’.<sup>17</sup> The first time she used methamphetamine she found it more intense and euphoric than her previous experiences with stimulants. At the time, she was living with her long-term partner and she went on to use methamphetamine daily, mostly staying at home when she did. She explained her typical activities while using methamphetamine as follows:

We were doing it in the house with just the four walls, but it was, yeah — it ended up just, you know, every time we did it, it would be at home and, I’d just clean the house — that was the big one — clean the house, listen to music, friends might come around and do it too. And we’d just play endless games of backgammon, and that was about it. Awesome [*laughs*].

At some point, Margot began to get very paranoid. She heard voices and suspected that she was being filmed in the shower and her bedroom. She said of the experience:

The main thing was hearing things; hearing voices; hearing people there when there weren’t. Thinking that there were people, like friends and family, inside the house or hiding around outside the house, watching me. It gradually led to thinking there were cameras in all the rooms. It was pretty horrendous. I ended up making a suicide attempt in 2007, ‘cause it had just got too much, but I still kept using it, yeah.

Clearly, Margot’s experience of psychosis was terrifying. She experienced delusional and frightening thoughts — that she was being watched and stalked by people she feared — distressing to the point that she tried to take her own life. She lived, for a time, feeling completely paranoid and fearful.

Through this experience, Margot remained in contact with her family. She explained she had a ‘lightbulb’ moment when, after a particularly bad night of hearing voices, her mother took her to a doctor. During the consultation, Margot realised that her mother thought she was being delusional. This was the beginning of Margot’s treatment for what she terms ‘methamphetamine-induced psychosis’, which included taking anti-psychotic medication and attending a stimulant-specific treatment service. She says of this realisation:

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<sup>17</sup> ‘Back in the day’ is a term meaning ‘in the past’.

It was a shock when I first found out that I had psychosis, because, you know, it all feels real. It feels entirely real, conspiracy theories you come up with and delusions all feel real. Even now, I have memories now of things occurring which, of course, didn't, but they feel real. So when I think about them there's a real emotion attached...because it feels like they did happen. I still sometimes lie there at night, going over things trying to pick whether there was anything about these instances that could have happened.

Margot's account of psychosis provides insight into how she managed this state. For Margot, being diagnosed as psychotic was key. It enabled her to label her frightening thoughts as delusional rather than real — a practice that she still continues. She also said that this 'realisation' did not immediately cure her and that even after diagnosis:

I'd come in and out of it, and that was one period where I realised that there was something wrong, but then I just slipped back into it again and then, you know, maybe for a few seconds I'd realise I was ill and then I'd slip back into it again. But, um, that was the first, sort of, realisation, yeah.

Dealing with psychosis was also assisted by the way in which she was treated by the staff at the main treatment service she attended. Margot could let staff at the service know that she was having a bad day and hearing voices — experiencing psychotic symptoms — yet the staff would still see her and speak to her as usual. Margot said:

The people there [at the stimulant-specific treatment service] had a real understanding of psychosis and I could go there and I could say, you know, 'Today I am feeling — I am hearing things'...I could go in there and be honest and they wouldn't just ring up the CAT team<sup>18</sup> just because I'd gone in there and said that I was hearing things.

There was a lot of trust there, which I didn't have with any other doctors.

Margot demonstrates the messiness of a state like psychosis. She initially existed in a state of paranoia, driven to a suicide attempt. Being told she was psychotic enabled her to sift through her thoughts and label them as real or not real, and manage her psychosis — to the point that she could call and make a treatment appointment even while experiencing voices in her head. Importantly, her treatment providers, through their practices, enacted her as a controlled psychotic person. They did this by simply continuing to provide treatment in the usual

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<sup>18</sup> Margot is referring to Crisis Assessment and Treatment Teams (CATT or CAT). CAT teams are known for being called when an individual is deemed out of control because of psychological distress.

manner — a counselling session, for instance— rather than refusing to treat Margot in that state.

Margot's enactment of herself as a psychotic body rejects conventional understandings of this body. Further, her account subverts the binaries of methamphetamine use as she is simultaneously psychotic and self-controlled. Her psychotic body is not a violent and out-of-control body — as is often inferred in authoritative literature (see Jenner, 2006) — but controlled to the point that she can attend a counselling session. Thus, like the accounts offered by Dwyer and Moore (2013), Margot demonstrates that the state of psychosis is messy and multiple, and that through diagnosis, medication, connection with her mother and her treatment encounters, she is able to enact herself as a controlled, psychotic body.

## **Conclusion**

In the two previous chapters, I have argued that methamphetamine and methamphetamine users are understood in very specific ways. Methamphetamine is constituted in scientific literature as a uniquely dangerous and toxic drug. Methamphetamine users are constituted in spheres of extreme absolutes — as hyper-controlled and aware and as hyper-violent and toxic. In this chapter I have explored how these very specific ways of constituting the subjects and objects of methamphetamine use shape accounts of consumption. To make visible the politics of ontology, I have illuminated how people who consume methamphetamine draw upon, or subvert, these absolutes through the ways they 'do' drug-using bodies. I have also made visible the material—semiotic networks that constitute bodies, showing that bodies are capacitated through these, and that attributes such as self-control and the ability to make the 'right' choices are a result of the connections and relationship individual are able to form. Addressing the practices of methamphetamine consumption in this way is studying this form of drug use as a matter of concern. This means that the political nature and effects of methamphetamine-bodies are brought to the fore, rather than materialising further 'facts' about methamphetamine consumption.

Participants' accounts indicated drug consumption practices were not clearly delineated in absolutes — showing that these practices are complex and multiple. Methamphetamine use may involve controlled, knowledgeable and expert practices. This entails people embodying themselves as self-aware, self-knowing and risk-averse. In some respects, these practices produced informed and less harmful drug use. In other instances, these practices supported a hedonistic aim — to educate oneself about the most efficient ways to get high or to manage a

seven-day drug binge. This disrupts a controlled/chaotic binary as controlled practices are employed in the pursuit of intoxication and hedonism. Moreover, controlled drug-using practices were not necessarily separate to knowing oneself as addicted; participants embodied themselves as simultaneously compelled to take methamphetamine and as able to exercise capacities such as strength of mind and self-control. Thus, while they drew upon broad and very conventional understandings of addiction, their localised practices subverted these understandings.

In the same way, practices identified in accounts as uncontrolled were also complex and messy. These included enacting oneself as addicted and taken over by the drug, as well as attributing behaviour and drug use to either traumatic events or the properties of methamphetamine itself. These are recognisable subjects in drugs discourse, where drug-using bodies are considered to be controlled by the drugs they use. In some cases, thinking about drug use in this way helped to manage or explain a lack of choice-making capacity. Yet, enacting oneself as compulsive and out of control — compelled to take methamphetamine because of an addictive personality or traumatic life events — did not exclude highly agentic practices. Methamphetamine was used in order to capacitate bodies to be powerful: to cope with trauma or even to steal drugs. Moreover, further subverting the absolutes of methamphetamine use, psychotic bodies in accounts were not necessarily out of control. As one participant demonstrates, this state may be frightening but controlled — that is, capable of dealing with hearing voices yet able to participate in active treatment practices such as counselling.

Focusing on material—semiotic relations in accounts, it was evident that, in addition to being complex and messy, controlled or uncontrolled practices were not due to personal attributes, but produced through the various networks within which subjects were located. Thus, controlled drug use was not the outcome of the choices of a rational individual, and uncontrolled drug use was not the outcome of the actions of chaotic and helpless individuals. Typically, those people who embodied themselves as controlled, knowledgeable users had access to resources such as a university education, a supportive family, a profession and/or financial security. For instance, those participants who actively researched the effects of methamphetamine and other drugs were students with access to resources such as computers and online forums. The young participant who manufactured his own methamphetamine had chemistry knowledge and the space in his back garden to set up a ‘lab’. Further, attending to material—semiotic networks show that uncontrolled, compulsive practices that participants

enacted as driven by addiction or trauma were not indicative of a defective or flawed subjectivity. Accounts of uncontrolled practices often emerged in assemblages lacking in social, economic and educational resources, perhaps even characterised by violence. These participants had limited access and connection to education, stable living conditions or home ownership and family support. They had high levels of state intervention in many aspects of their lives. The multiple ways in which they were able to embody themselves had common features in that they had constrained ability to exercise power and choice.

Accounts of methamphetamine consumption and the different ways in which participants were able to constitute themselves have implications for the way in which drug use is addressed. If the drug-using subject is seen as the sole point for intervention with regards to drug-related harm and other drug-related effects, then this others the networks and assemblages that produce drug use. Yet, as the above discussion indicates, individuals are embodied through these networks and their capacity to manage their drug use and their lives is shaped by the connections and relationships they make. Having explored consumer accounts and the assemblages of methamphetamine use, I now turn to the ways in which practitioners respond to and constitute methamphetamine use. In the following chapter, I explore the ways in which methamphetamine consumption is addressed through harm reduction and/or treatment.

## Chapter 7: Addressing methamphetamine-related harm: Accounts of treatment and harm reduction practice

### Introduction

To illuminate the ontological politics that come into play in the practice of drug consumption, the previous chapter addressed the second of my research questions — how do consumers and service providers draw upon, reject and subvert dominant discourse through consumption and harm reduction/treatment practices? I interrogated the extreme absolutes that underpin how methamphetamine and methamphetamine users are materialised in Western liberal societies (Fraser & Moore, 2008; Keane, 2002; Sedgwick, 1992; Seear & Fraser, 2010a), showing how these may come to bear on the practices of methamphetamine consumption. To do this, I analysed accounts of methamphetamine consumption, arguing that people ‘do’ their bodies in particular ways through this practice (Mol & Law, 2004). I found that respondents embraced dominant discourses and the extreme absolutes of methamphetamine use in order to perform particular drug-using bodies, including expert, extreme, addicted and traumatised bodies. Yet, slippages, resistance and messiness were also evident, showing the limitations of these absolutes and their political effects. For example, knowledgeable and controlled practices, such as researching drugs, were carried out with a hedonistic intent, to party and get high; engaging in expert and controlled methamphetamine-using practices was not necessarily separate from knowing oneself as addicted. Thus, while participants evoked extreme absolutes, their consumption practices simultaneously rejected and subverted these absolutes. Accounts of methamphetamine consumption also illustrated the way individuals’ connections and relationships manifest or disallow particular capacities. Attributes such as being knowledgeable about drugs and brain chemistry emerged from assemblages characterised by resources such as education and access to tools such as computers. Characteristics such as feeling powerless over methamphetamine emerged from assemblages characterised by a lack of access to significant social and economic resources, which constrained the choices individuals could make.

I now turn to the accounts of methamphetamine service providers in order to further analyse how the binaries that underpin methamphetamine use shape harm reduction and treatment practices, and the ontological implications of this. My argument uses analyses of ‘change’ to understand these accounts. I chose this particular concept because it is central to AOD treatment discourse and a constant theme in service provider accounts. I trace this concept, examining some of the ways in which it is enacted within accounts, and its relationship to

‘control’. The accounts that I analyse are drawn from interviews with workers at a range of AOD organisations that offer harm reduction and/or treatment services to people who use methamphetamine. While this chapter features accounts of service providers, in order to illustrate some points I make about service provision, I also include service user accounts.

The AOD organisations involved in this research were diverse and targeted different groups of people using drugs. Of all the services, only one was a specialist stimulant treatment service. Treatment practices at this particular organisation were markedly different from those at the other AOD organisations I researched. Treatment here was based upon talking therapies and enacted clients as highly capable, choice-making individuals. These practices draw upon the scientific and treatment literature on methamphetamine use (see, for example, Jenner & Lee, 2008). Other AOD organisations involved in this research targeted groups such as young people who use drugs, people who inject drugs, or people withdrawing from drugs. While these services are accessed by people who use methamphetamine, they were also accessed by people using heroin, cannabis and alcohol. Accounts of service practice were therefore varied. Some services were inpatient, allowing people to detox from drugs for a week or so, while others involved case management — that is, assisting people in various aspects of their lives, such as accessing treatment, attending General Practitioner appointments and finding housing and work. Some provided counselling and others a safe space with access to general health care, food and harm reduction services, such as NSP, if needed. While divergent, these treatment practices were shaped within the current conditions of possibility and shared conventional assumptions about drugs and drug users. Moreover, practices were shaped by issues such as funding and resources. All of these AOD services were funded through government. Funding for government AOD services is typically tenuous and parsimonious, constraining the level of support services can offer clients, particularly if clients are experiencing economic and social hardship (MacLean, Berends, Hunter, Roberts, & Mugavin, 2012; Ritter, McLeod, & Shanahan, 2013).

I consider the practice of service provision using insights from Gilles Deleuze and STS. That is, I assume a body is more than, and not limited to, its physical presence (Buchanan, 1997; Deleuze & Guattari, 1987); physicality is obviously necessary but not privileged. Bodies emerge through desiring forces and the connections and relationships they make. Moreover, a body is not prior to practice but emerges through practice (Mol & Law, 2004). AOD harm reduction and/or treatment practice can be thought of as a range of ‘discrete assemblages’ (Duff, 2012, p. 145) with key temporal and spatial differences, and involving various objects

and subjects that result in the emergence of multiple bodies with varying capacities. For instance, the practice of an inpatient withdrawal service enacts a body with limited capacity for control or power. This practice obliges the subject to withdraw from prior connections and relationships and reside in a highly contained and regulated space for days or weeks. The subject can be medicated if it is deemed necessary by the expert staff within the service. In contrast, the practice of outpatient talking therapies, such as those based on CBT, attempts to bring into being an active treated body. This practice obliges subjects to become self-reflective and self-aware in order to modify their behaviour. Subjects are required to manage their own time and space, making and keeping appointments with their treatment practitioner, maintaining their existing connections and relationships, but learning how to manage these in order to control, reduce and/or cease drug use. Considered in this way, harm reduction and/or treatment practice is the active task of enacting and re-enacting bodies with varying capacities.

In addition to conceptualising harm reduction and/or treatment practices as productive of particular bodies, I draw upon a theoretical insight from Mol and Law (2004) with regards to medical intervention. These scholars view medicine as:

[A] range of diagnostic and therapeutic interventions into lived bodies, and thus into people's daily lives. (Mol and Law, 2004, p. 58)

They argue that, in accordance with this assumption, the effects of medical interventions should be evaluated by:

not only their effectiveness in improving one or two parameters, but the broad range of their effects deserves self-reflexive attention. Not all of these effects should be expected to be for the better. In articulating how it is doing, in considering the effects of its activities, medicine would be wise to confront its own tragic character: medical interventions hardly ever bring pure improvement, plus a few unfortunate 'side-effects'; instead they introduce a shifting set of tensions. (Mol & Law, 2004, p. 58)

This way of conceptualising medical intervention can also be applied to AOD service provision. Few would argue that AOD harm reduction and/or treatment practices ever result in 'pure improvement', and scholars have identified the tensions and paradoxical nature of these interventions.<sup>19</sup> Thus, my aim in analysing various harm reduction and/or treatment practices is not to compare and evaluate services, assessing their suitability for people who

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<sup>19</sup> See, for example, (Fraser & valentine, 2008) and (Holt, 2007) on methadone maintenance treatment and (Moore, 2009) on harm reduction services.



use methamphetamine. Rather, in addressing accounts of service provision, I trace the concept of change in order to illustrate the ways in which practice (re)enacts or rejects binaries that underpin drug use, such as voluntariness/compulsivity, and also to consider the effects of intervention in terms of the 'shifting set of tensions' they may introduce to people's lives (Mol & Law, 2004, p. 58). Moreover, noting the various ways in which change is conceptualised, I also bring to light the ontological politics involved in the enactment of treated bodies, analysing the constitution of these bodies in relation to dominant discourses and the neo-liberal episteme.

To pursue the argument that follows, I first show how change is broadly understood in AOD discourse. I then present accounts of service provision that evoke change as dependent on individual attributes such as self-control and choice-making capacity. Related to this, I discuss the development of individual capacity as the object of treatment. Finally I describe alternative ways in which change emerges in accounts of service provision.

## **Change**

The concept of change is central to harm reduction and treatment services for people who use drugs, as these aim to intervene (and change) drug use practices in specific ways. An example of the centrality of change to harm reduction practice is found in NSPs. Through engaging with NSPs, people who inject drugs are expected to change their injection practices from unsafe (such as sharing injecting equipment) to safe (such as not sharing injecting equipment). This change is facilitated through the provision of clean injecting equipment and advice from an NSP worker or written information supplied by the service. Through undertaking the practice of safer injection, the drug user then 'does' his or herself as a responsible injecting drug user. As drug use practices shift, change occurs. The body enacted through the practice of using clean injecting equipment has changed from an irresponsible drug user (sharing injecting equipment) to a responsible drug user (not sharing injecting equipment) (Moore, 2004). As I argued in Chapter 5, a self-controlled and knowledgeable drug-using body emerges from harm reduction practices (such as NSP), one with the capacity to change one's actions in accordance with the correct information and resources. Change, then, is conceived as brought about by the individual's capacity to act on the information and/or services provided and, in this way, is central to harm reduction practice (Moore, 2004).

‘Change’ is also integral to treatment discourse and an overt goal of treatment practice. A well-known way in which ‘change’ is conceptualised in AOD treatment discourse is ‘the stages of change’ (Greenwell & Brecht, 2003, p. 1103). This model was originally conceptualised by Prochaska and DiClemente (1985) and is still widely used in the field of AOD treatment. The model conceptualises drug use (or any addictive practice) in stages, classifying people according to where they sit in terms of their ‘readiness for change’ (Jenner & Lee, 2008, p. 55). In the federally funded guide for treating methamphetamine use, *Treatment approaches for users of methamphetamine: A Practical guide for frontline workers* (Jenner & Lee, 2008), the stages of change are listed as:

- precontemplation, where the person is not considering change
- contemplation, where the person has not yet cut down or quit, but is considering change
- preparation stage, where the person has made a firm commitment to quit or cut down
- action stage, where the person has recently cut down or quit
- maintenance stage, where the person has cut down or quit for some time
- relapse, where the person has started to use again (p. 58)

The conceptualisation of ‘change’ produced through this model centres on the ‘readiness’ of the individual using drugs. Thus, treatment practice can only result in client change in cases when the client is ‘change ready’. For instance, in their guide to treating methamphetamine use, Jenner and Lee (2008) state:

Harm reduction and brief advice are suitable approaches for those not considering change. Those considering change can benefit from motivational enhancement, education, counselling. Those in the preparation or action stage can benefit from structured counselling, and those in relapse can benefit from motivational approaches and skills building. (p. 58)

The assumptions that underlie this statement have the effect of removing treatment practices from scrutiny. If the client does not change (and treatment has therefore not been successful) this is not related to treatment practice but because the client is not at the correct stage of change. This theory of treatment enacts drug-using bodies as anterior to treatment practice with treatment outcomes dependent on the change readiness of these bodies rather than the quality or suitability of practice.

I argue, therefore, that both harm reduction and treatment practices assume the capacity for change resides solely within the drug-using body. In order to reach a successful outcome, both practices require a change-ready drug-using body — one that is amenable to learning how to make the ‘right’ choices, which are ‘free’ and not driven by compulsion. The change-ready body in this way mirrors that of the neo-liberal citizen. Given the centrality of this active citizen in Western thought, it is unsurprising that locating capacity for change solely in the treated body is mirrored in participants’ accounts of service provision. And yet, in practitioner accounts, change also emerges as a more complex phenomenon. Sometimes change was conceived as a result of individuals making the right choices, but chance, environment, partners, homelessness and other aspects were also seen to play a role in change. Some workers needed to see change in clients in order to find reward in their work, and felt exasperation with clients that were not ready to change. Others expressly stated they did not need to see change; some considered clients unchangeable and understood their practice as providing respite. Thus, while harm reduction and treatment discourse reifies change as dependent upon individual agency, service provider accounts complicate this understanding as they understand change in multiple ways, even rejecting the need for client change. Below, I trace some of the ways in which change is constituted in accounts of service provision.

### **Change and individual capacity**

In this first section, I present accounts of service provision in which the capacity to change was considered an individual attribute. I discuss accounts of service provision from workers at two services with distinct client groups, and consider the varying ‘set[s] of tensions’ (Mol and Law, 2004, p. 58) that arise from considering change in this way. I then discuss the concept of choice in relation to change and present an account of service provision in which practice intervened upon the individual’s capacity to make choices, rather than his or her drug use *per se*, arguing that this is a logical trajectory if change is dependent upon individual attributes.

The first account of service provision I examine in relation to the concept of change was provided by Eve, a nurse at a primary health care facility. This service was typically accessed by people Eve described as:

Mostly males, probably over their 30s who are quite, they’ve got multiple complex problems...most of them wouldn’t have, don’t hold down employment, so I think that’s why they’re more likely to come to our service. A lot of them have a forensic

history...most of them are older and they've been using [drugs] for quite some years and with multiple problems like dual diagnosis, mental health issues as well.

Eve also said that her clients usually injected heroin, had a long history of drug use and were often homeless. The primary health care service she worked for operated from a purpose-built facility and provided a range of services including a large OST program, NSP, a health, mental health and referral service; and a drop-in area where people could obtain tea, coffee and food. The service was constructed so that the client area was an open space, with the service manager and other workers' offices surrounding it. The spatial implications of this were that management were highly accessible to clients and staff. It also enabled a high level of surveillance, particularly as most offices (including the manager's) had glass walls. It included private rooms in which clients could receive counselling or medical care, although the waiting area for these services was also highly visible and located very near to the reception desk and front entrance of the building.

The second account of service provision I consider in this section was provided by Tess, a nurse at a stimulant-specific service. The client group that accessed this service had significantly more resources than those at the primary health care service. Tess described her clients as typically 'self-motivated'. She also said that 'a lot of them are working, they've got high functioning positions'. The stimulant-specific service provided medical services but focused on practices such as motivational interviewing and CBT. These practices are based upon 'best practice' for methamphetamine use (Lee & Rawson, 2008). The stimulant-only service was also purpose-built, situated within a general AOD service. It was separated from the wider service and had a private waiting area, specifically so that people who used the service could wait for their appointment away from the other clients (mostly people who used alcohol and heroin). Rather than creating a space where clients were able to be seen and surveyed (such as in the primary health care service described above) the intent was to create a space affording clients privacy.

### **Change and the need to 'prioritise'**

Change resulting from individual capacity was central to both Eve and Tess's accounts, and yet this concept produced different sets of tensions because of the varying circumstances of their clients. Eve's account materialised change as related to the capacity of her clients to prioritise. She explained:

[You] see less change...like maybe a little bit of change and then back to where you started again. Like they may start to, but then it just seems like more of a quicker cycle from when they start...making a few changes and then they drop back into that drug-taking cycle.

**Is that frustrating for you?**

It does get frustrating because I guess you feel like you're doing all this work for them trying to — whether it be making appointments and do stuff with their health and that kind of stuff — and it's just not their priority at the moment, like the priority is still that drug-seeking kind of behaviour.

Eve later qualified that people were not required to *want* to change in order to access the service:

They don't have to want to change or work on their other stuff. Like to me, being homeless...would be massive, but for them, their priorities are just a little bit different. They might not be at that [stage], they're not ready for change.

With these statements, the capacity for change is evoked as an individual attribute, in that change occurs as a result of the client's ability to prioritise. Eve notes that her practice is futile if the client's priority remains 'drug-seeking' behaviour, reflecting the assumptions of the stages of change model (Jenner & Lee, 2008, p. 58) in which successful practice is dependent upon an *a priori* change-ready client.

There are tensions evident in Eve's account between her concept of change, her clients as choice-makers and the level of control and choice apparent in their day-to-day lives. The assumption that the clients of the primary health care service prioritise drug-seeking behaviour and are not ready for change constitutes them as individuals who are unable or unwilling to make the right choices. Yet, by her own account, Eve worked at a centre frequented by people who were extremely socially and economically marginalised:

I mean you'd love to be able to help them more, as in like when the people come in for the pharmacotherapies and they can't afford to start. There are agencies that can help them out from time to time but it's not a guarantee. And I guess the other thing, like even down to like housing, housing is a massive thing. And at the same time you refer them to other agencies and sometimes they come back, and they're like, I'd rather live on the street than where, you know, they've been referred to, because it's just not safe, and that kind of thing. I mean food and all that kind of stuff. We have

food from time to time but it's not something that we can keep up all the time for them.

Clearly, Eve understood the dire financial and living circumstances of her clients, as well as the limitations of the service at which she works and the way these financial constraints shape her practice. She is also well aware of the dearth and quality of other services accessible to her clients and is obviously frustrated by this situation. Yet, this understanding of the lived experience of many of the clients of her service is at odds with Eve's conceptualisation of change. It is possible that Eve's clients did prioritise better living conditions and quality of life, but the immediate needs necessitated by the material and social deprivation they experienced might have made this priority difficult to achieve. By describing her clients as prioritising drugs over other more important needs such as housing, Eve locates the responsibility for their situation in their inability to choose correctly, rather than the socially and economically deprived networks they were enmeshed within.

Conceiving of change as the result of individual priorities and choices seems problematic for a group of clients such as those that access the service at which Eve is employed, not least because of their precarious connections to employment, housing and income. However, this understanding was also reproduced in service user accounts —such as that given by Mr D, a 32-year-old client of Eve's service. Mr D was an atypical client of the primary health care service: he had some paid work and relatively stable accommodation, yet he had also previously been homeless, used heroin and methamphetamine for many years, and survived on a very low income. When asked whether it was possible for people using the primary health care service to change, he said:

There is a choice in there at some point. What that choice is, and when it comes, I don't know, it's different for everyone, everyday...I see that a lot, people that, you know, they either do or don't want to change. If someone doesn't want to change well, you know, what are we supposed to do? What, how much is anyone else supposed to care, you know?

Mr D's account enacts the individual as the locus of change; a person makes the choice to change or not. If they do not want to change then it is questionable as to whether they are worthy of care. Here, the emphasis is on *wanting* to change — whether one *can* change is a moot point. The individual is judged on their aspirations for themselves. Indeed, Mr D's aspirations were significant:

I'm trying to get my life together because I'm trying to start a business, I'm trying to run a film and recording studio ...I'm trying to be responsible ...because you can't take drugs and work as a professional, you know.

Mr D clearly wanted the 'right' things; he aimed to own a small business, be professional, be abstinent and be responsible. With these expectations of himself, Mr D claimed it was possible to change. Like Eve's account, Mr D's account is underpinned by neo-liberal assumptions about the capacity of the individual and enacts subjects as freely able to choose or prioritise aspects of their lives. Both accounts demonstrate the political nature of neo-liberal discourse — in that it others the lived experience of these clients and how the networks within which they are enmeshed shape the choices and priorities in their lives. These accounts also illuminate the resonance and power of the figure of the neo-liberal subject — a citizen accountable through the choices he or she makes. Although Eve and Mr D had intimate knowledge of the lived experience of homelessness and long-term injecting drug use, they drew upon this figure to explain why people did not change. In doing so, they responsibilise an extremely marginalised group of drug users, othering the role that access to resources plays in the capacity to make the 'right' choices.

### **Changeable clients**

The second account of service provision I use to consider change as the result of individual attributes was provided by Tess. As I have noted above, the stimulant-specific service at which Tess worked offered 'active' treatments such as CBT and motivational interviewing. This was specific to this service and reflects treatment 'best practice' for methamphetamine use (Lee & Rawson, 2008). The organisation was also notable in serving (reportedly) a greater proportion of high-functioning people than did Eve's primary health service. Tess said of her clients:

They are working; they might be working in quite high positions. This is generalising hugely, but probably if you did the stats....a larger proportion of them are in the workforce. Maybe running their own businesses so they're people that have probably been quite capable in lots of ways at developing things and being self-initiating and studying, at uni. They're social; they're more social in general. Probably...quite receptive to support of therapy, the CBT type models, things like that perhaps. All of those sorts of things, yeah.

This description of her clients is very different from Eve's, and suggests that the two services were accessed by client groups with different access to social and material resources. At the

primary health service, clients had poor connections to housing and employment, and were likely to have a prison history and to be long-term drug users. Tess's client group had strong connections to the workforce (often in positions of authority) and/or university, as well as strong social connections. Whereas clients accessing the primary health service were driven by their immediate needs, such as food and shelter, Tess's clients had these needs fulfilled and were looking specifically for treatment for their methamphetamine use.

Change was central to Tess's treatment practice. For her, it was a rewarding part of her job, as she explains:

I guess having that one-on-one contact with people about something that's so personal, it's having such an impact on their lives, and the lives of the people around them, and being part of that process of change...being around people at a time when they are wanting to change too and yeah, thinking about change, thinking about what's happening in their lives.

This statement inscribes Tess's clients as thinking and reflective bodies, aware of what is going on in their lives, and wanting change. These bodies are recognisable as hyper-capable methamphetamine bodies. Such bodies enact, and are enacted by, an active and reflective practice. Tess describes her practice and her clients in the following statement:

So a service that's really respectful...that's engaging with people that are experienced and know what they're talking about, because they will test it out. And I think they need to feel that you've got some level of knowledge and understanding, that you've got something to offer as far as treatment, and a belief in what you're offering — that it works and it can work for them — a skill-based intervention to work on developing their skills and their understanding.

Here, Tess explains that treatment practice is formulated with the expectation that clients are knowledgeable and have high expectations of treatment and themselves. At the same time, she shows how practice further capacitates these bodies through developing their skills and understanding.

When describing treatment practice, Tess reflects some of the insights offered by Rose (1999) concerning talking therapies or the 'psy' disciplines. For instance, Tess articulates that her role in treatment is necessarily collaborative:



I really try and think of it as collaboration with a person. You're there along the way to support...you know, and offering some direction, but bringing out what you can of people.

Rose (1999) argues that talking therapies purport to be collaborative but involve clients shaping themselves in accordance with dominant neo-liberal norms; this may be the 'direction' offered by Tess. Tess also refers to providing 'tools' for people to work with in their own way:

So in that sense you know it's the understanding that you're providing that, an opportunity for a person to, or some tools for them to use, to utilise in that way whether they take that up or not, whether they decide in the end that's where they want to go, that's their decision too.

Rose (1999) argues that talking therapies provide citizens with the tools needed to self-regulate in accordance with dominant norms and ideologies. And ultimately, clients are expected to take on the techniques or tools conveyed to them by the therapist by becoming 'regulators of their own thoughts' (Proctor, 2008, p. 252). These examples show some of the ways that Tess's practice reflects the observations about 'psy' therapies made by Rose (1999) and enacts active and reflective citizens. As I will show below, these practices are congruent with the way people accessing Tess's service embody themselves and the material—semiotic networks within which they are enmeshed. That is, through their strong connection to work, family and so on, Tess's clients have the capacity to make the 'right' choices and to be active in treatment.

Tess's treatment practice shares similar assumptions to that of Eve's. Both service providers aim to provide clients with an opportunity to change and whether clients take this opportunity is for them to decide or 'prioritise. Yet, Tess's client group is very different from that of Eve's, and has access to significant resources that are perhaps more productive of the capacity for change. Accounts from clients accessing the stimulant-specific service suggest that they were able to use the tools provided through Tess's practice to change and were very satisfied with the service. For instance, Cat, a university graduate who managed an online business, was a client at Tess's service and said that she liked it because 'everyone was understanding and informative'. She said:

It really does provide me with some insights, and actually, you know, helps me with strategies and shit like that because I've found a lot of counsellors are pretty fucking shit.

Sean, a 39-year-old artist and an athlete, also said that he found the service very helpful because of the skills he had learnt:

I'm at this point where I wish I wouldn't ever take it [methamphetamine] again but I think that's unrealistic. But I feel like I'm much more in control, like I've learned all the situations that can trigger me craving it, and learnt so many different techniques to stop me having access to it, so it's not easy to get.

The strategies or skill-based interventions employed at the stimulant-specific service were consistent with the way Cat and Sean enacted their bodies and their lived experience. While these two individuals were experiencing drug use as problematic (as evidenced by them accessing treatment), the networks and assemblages within which they were enmeshed provided them with access and connection to a reasonable level of social and material resources. Cat lived with her parents and managed a business. She was university-educated and looking for a graduate position. Sean was a relatively successful artist, who was also well known for his athletic ability.

Yet, while the practices of the stimulant-specific service enacted autonomous, self-reflective treated bodies, the very act of accessing treatment requires one to 'do' oneself as a compulsive drug-using body, at odds with the self-controlled subject. This was evidenced in Cat's experience of an inpatient withdrawal service. Cat explained that this form of passive treatment did not help her:

You can't just go and sit somewhere for ten days and then expect to be better when you get out like, you know, you're still the same person. So I don't think that detox is appropriate for me to quit because I just don't see how it really helps.

As noted earlier, this particular treatment practice is characterised by highly regulated space, where clients are expected to follow a routine as well as adhering to many rules. During Cat's stay, a staff member was rude to her because she had inadvertently broken a rule of the service:

They were just so mean. Like I remember my ex came and we went... to have a smoke outside and like, I didn't realise we weren't meant to be outside. And there was

this nurse and she was just like yelling at me and I'm just like fuck, 'I didn't even know I wasn't meant to be here, like, you could just be nice about it'.

Yelling at clients because they have been unknowingly non-compliant is a highly disrespectful practice and enacts them as disobedient and childlike. For Cat, this practice was incompatible with the way in which she embodied herself and she left the service shortly afterwards. This is not to say that it is common practice to belittle clients who inadvertently break the rules at inpatient withdrawal services, but Cat's account draws a stark line between the ways in which she is constituted as a treated body by the stimulant-specific service and the inpatient withdrawal service.

Sean also noted the tensions that arose in accessing drug treatment. He said that he found it very difficult to attend the stimulant service because of the way it made him feel about himself:

It's kind of freaky to go into this place where there's like, you know, drug addicts and stuff, it's like, 'oh my God, this is what's happened to me?' And you can see...other people waiting around...And also just how it says 'drug clinic' out the front. If it were a bit more private or something I probably would feel more comfortable.

Later he said of himself:

I felt really disappointed in myself...how has this happened to me, who's supposed to be so in control of everything that I've got to go and get drug counselling. I found it very, I don't know, a little bit disappointed in myself and embarrassed and humiliated to think that I needed to get drug and alcohol counselling.

Sean was uncomfortable with the label of the service identifying him as the client of a drug clinic as well as the 'drug addicts' with whom he had close contact when attending the service. For him, attending drug treatment required that he embody himself as someone who was out of control — and this was humiliating — but also at odds with the ways in which he typically embodied himself.

As a practitioner, Tess was aware of the tensions that arose when self-controlled and knowledgeable bodies encountered treatment. To address this tension, she explained that she considered her clients as 'people that have an issue with substances at that particular point in time in their lives' and that her clients were not required to 'label' themselves. Expanding upon this she said:

I think it probably comes back to some of their own personal characteristics and attributes that stop them as far as thinking ‘well, that’s not me, I don’t see myself in, as a druggie’. They will say that; ‘I’m not like that’.

With this statement, Tess enacts her clients as having worthy attributes. She also notes the disjunct between the characteristics of her clients and those attributed to ‘druggies’.

In addition to the actual practices of treatment addressing the discomfort high-functioning clients may feel when attending the stimulant-only service, consideration had also been given to the design of the service space. The physical space of the clinic was separate and private. It contained a table with magazines to read and a pot plant, as well as a couch. While clients had to walk through the front entrance of the general AOD service, they could quickly go into a confidential and pleasant space. Accommodating the unease people experienced at being linked to the stigmatised body of the drug user is not a general feature of AOD sector as evidenced, for instance, by the very different space of the primary health care service. This is not to suggest that all services should offer the same practice; the methamphetamine specialist service had different aims to that of the primary health care service. The specialist service aimed to assist people to control, reduce or cease their methamphetamine use. The primary health care service aimed to be a ‘one-stop shop’ for people who inject drugs — primarily heroin — who had a much broader range of needs. However, the differences between the physical spaces of these services illustrate the political nature of treatment practice. The practices and spatial considerations of each service materialise very different treated bodies. Clients of the primary health service are subject to high levels of surveillance, visible to management when accessing a drop-in space, and to other clients when using services such as the NSP and pharmacotherapy programs. These practices oblige clients to embody themselves as drug users. On the other hand, clients at the specialist methamphetamine service are afforded privacy and a safe space away from drug users. These clients are not obliged to embody themselves as a druggie to access treatment. They are able to understand themselves as a different type of drug user — one that can exercise self-control and be compliant in a treatment environment. In this way, they are reflective of the bodies enacted through active treatment practices outlined in Chapter 5.

Yet, while Tess’s practices enact a highly controlled user and considerable effort is made to provide this group of clients with a private, quiet space to receive treatment, this is also a group of drug users understood as uniquely violent and psychotic. When asked about the

reputation of methamphetamine users, and whether this tallied with her experience, Tess replied:

I think people were really wary about this group of people and they're actually really reasonable. They've been fantastic, and part of it, maybe that they're protected from that [being thought of as a violent methamphetamine user].

Here, she suggests that one of the reasons her clients' behaviour is reasonable is because they have been accorded a separate space and protected from the general AOD waiting area. This is reinforced by Margot's experience. Margot at various times experienced psychosis and said of the waiting area:

it used to feel good being able to go and sit in that separate little room to wait...mainly because I was feeling so jumpy and so...because I'd go in there hearing things and stuff... that's probably common to quite a few methamphetamine users, those experiences and there would be, probably, a lot of paranoia and feelings like that going on. So I think it probably was a really good idea.

Margot found being able to have a quiet place to wait for treatment beneficial to the way she felt, and thus helpful to being able to embody herself as a 'reasonable' client. Tess's observation and Margot's assessment of the waiting area show how practice and space can act to constitute particular types of treated bodies.

On a related point, Tess, noted that many of her clients had mental health problems:

At the moment we're getting a range of people. Quite a lot of our people coming through do have depression, anxiety, and they've experienced psychosis, they do have those other mental health issues to quite a large degree as well. They seem to be able to still access the treatment.

Thus, mental illness does not, in the case of the stimulant-specific service, disqualify people from CBT or from being active, knowledgeable clients. This is congruent with Margot's experience (detailed in the previous chapter) where she describes being treated at the stimulant-specific service while experiencing psychosis. So while Tess enacts highly knowledgeable bodies through her treatment practice, at the same time these bodies may be psychotic, anxious or depressed. This subverts some of the very conventional ideas around mental illness and drug use. It manifests clients of the service, whether with additional mental issues or not, as capable of undertaking CBT and of change. Clients are therefore enacted through Tess's practice as simultaneously controlled, active and psychotic.

Both Tess and Eve enact their clients as capable of change. Yet, because of the various assemblages within which these clients are enmeshed, the interventions produce different sets of tensions. Eve's clients experience significant marginalisation and have limited capacity to connect with economic and social resources such as housing and employment. Tess's clients can make these connections and, in doing so, are able to appropriate the neo-liberal subject even when depressed and psychotic. I now discuss an account which also enacts the neo-liberal treated subject before further discussing its political implications and effects.

### **Change and choice**

Linked to the concept of change as resulting from individual capacity is the treated body's capacity for choice. The capacity (or incapacity) to make choices driven by sufficiently pure volition (Sedgwick, 1992), that are free but responsabilised (Rose), is central to our understanding of citizens. Neo-liberal discourse assumes people who use drugs are typically devoid of the capacity to make the right choices (Keane, 2002; Sedgwick, 1992). Their choices are not made freely because they are driven by compulsion and addiction. A corollary of this assumption is that drug treatment practice should improve the capacity to make the right choices, and I now feature an account of service provision where this was the case. The account is from Gillian, a senior case worker, and her treatment practice can be seen as addressing her clients' choice-making capacity.

Gillian's treatment practices emphasised a 'relationship-based' approach, and her first priority was thus to establish a relationship with the client. This involved being able to talk openly with clients, to support them and link them with various services and resources. Through this relationship, Gilliam aimed to 'empower' the client. Central to empowerment was enhancing the capacity of the client to make the right choices and to change. As Gillian explains:

It's basically forming the relationship-based approach with the client where they're going to be able to feel safe enough to be able to talk to you, where they're going to feel empowered. It's about empowering the client, looking for change. It's about providing support; it's about showing them what other facilities are out there. I guess at times it's setting up a bit of a pyramid so that they know that they've got choice and from there they will be able to figure out what's going to work well for them.

The object of intervention here is the client's attributes and the goal is to increase their ability to make the right choices. This did not necessarily involve ceasing drug use, as Gillian said:

It's about giving them information so that they can make the right choices and harm minimisation...like it might be about safe techniques in using. It's about giving them the choices so they can make smart choices for themselves.

Here Gillian's treatment practice 'does' a harm reduction agentive drug-using body. This is a body that can use drugs responsibly, making 'smart choices'. Moreover, this is a body that understands itself on a biological level, and as Gillian noted:

For me I like to work through with clients on getting them to understand chemically what occurs because I think that's important.

**Why is that important?**

I think that a lot of people might feel good in having it, but they've just got no idea of what's going on in their mind while it's occurring and I think that to make the choices that you need to make you need to have an understanding of what's going on.

Gillian's practice of informing her clients about what is 'going on in their mind' enacts these drug users as biological citizens (Rose, 2007); as individuals who consider the choices they make in terms of their neural implications.

Neo-liberal discourse understands addicted subjects as flawed and damaged because they cannot make the right choices. Gillian's treatment practices followed these assumptions through to their logical conclusion. The object of treatment in Gillian's practice was not drug use *per se* but the client's *capacity* to make the correct choices. Gillian provided clients with the information required to make the right decisions but then took this a step further, empowering her clients and increasing their capacity to act upon this information. These treated bodies are not those enacted through CBT in that they are not required to scrutinise their thoughts and change the way they think. Instead, they are bodies capable of being empowered and supported to make the 'right' choices. They are appealing in that they are rational, active drug users; once shown the correct choices to make, they will make them. Yet, intervening in this way also produces a specific set of tensions. While increasing the capacity of individuals to make choices may contribute to their sense of empowerment, it also obliges them to take sole responsibility for the result of their choices. The client group that Gillian worked with was young, often in state care and usually with minimal levels of education and income. If, in supporting them to make choices, there is no consideration of the way these choices are shaped through the networks and assemblages clients are implicated within, it is possible that they could assume complete responsibility for their precarious relationship to social and material resources. Thus, while undertaking to empower clients,

effectively giving them a sense of agency, there are tensions between this goal and the lived experience of Gillian's young clients (Moore, 2009; Moore & Fraser, 2006). Gillian's practice others the drug assemblages within which her clients are enmeshed. These assemblages may shape what she considers to be unsafe drug use, rather than this being the result of her clients making the wrong choices.

While it is important to note the tensions in the way Gillian's clients are evoked, this is not to disparage her practice. AOD treatment practitioners are limited in what is achievable. Their practices are shaped by the stated aims of their services, funding agreements, and connections to other services that might provide support to clients. Given the circumstances of Gillian's clients, providing clients with information about drug use is an activity that has strategic benefits (Moore and Fraser, 2006). Positioning clients as individuals with the capacity to make the 'right' choices responsabilises them so that they are answerable for their marginalisation. However, providing them with the information to make decisions that might minimise risky drug use is a pragmatic way of supporting these individuals, given the limitations of what is possible to accomplish through harm reduction/drug treatment services.

### **Risks and benefits of responsabilising methamphetamine treated subjects**

In this section I have discussed how service providers conceptualise change as related to individual capacity and the various sets of tensions that may arise. I also considered the specificity of the stimulant-only service — noting how its treatment practices manifest a uniquely active drug body. I have argued that considering change as related to individual capacity is problematic for those people enmeshed in networks devoid of key social and economic resources. Their lived experiences are 'othered' by the evocation of the neo-liberal ideal. These individuals are seen as capable of prioritising and therefore as responsible for where these priorities have led them. And while change is demanded of (and by) those individuals who experience a sense of control and power in their lives, tensions arise in treatment encounters. Entering treatment effectively means 'doing' oneself as a compulsive and problematic drug user, a body at odds with the neo-liberal citizen. In some cases, practice could accommodate the sense of discomfort individuals had with the treatment encounter. This was done through strategies such as not labelling clients and creating a space in which their comfort and privacy was foremost. Yet these considerations are not applied equally to all people accessing treatment services, as other services subject clients to high levels of visibility and surveillance. Further, a corollary of linking client change to individual attributes and capacity is that these then become the object of treatment. Treatment practice intervenes



to empower bodies to make the ‘right’ choices and enact change. While these treatment practices provide a political alternative to those that enact drugged and passive bodies, tensions also arise when the lived experience of individuals constrains the choices they are able to make.

While practices that enact drug users as rational, autonomous beings can seem beneficial, Moore and Fraser (2006) argue that there are risks with this approach. These risks are illustrated in the accounts of service provision above. Further, Moore and Fraser (2006), Sedgwick (1994), also argue that enacting the neo-liberal is also risky because the concepts of free will and autonomy associated with this ideal are necessarily established with their binary opposites — compulsion and addiction. Thus, the flipside of embracing the neo-liberal subject is that it must always exist with failed neo-liberal subjects, leading to binary categories such as good drug users/bad drug users. As an alternative to the neo-liberal subject, Moore and Fraser (2006) argue that de-centring the subject and recognising a multiple and fragmented subjectivity is a possibility, but that this too can be problematic, reinforcing drug users’ marginalised status:

definitions of the subject as fragmentary, non-rational, always in a state of flux, may be applied only to social groups that are already deeply marginalised, rather than to all subjects, including the most ‘respectable’. This would likely reinforce popular prejudice and stigmatisation, and may further entrench discrimination in legal, employment, health and welfare contexts. (p. 3042)

Moore and Fraser (2006) do not propose a ‘correct’ way of thinking about the drug-using subject in harm reduction, but seek to make visible the political nature of this subject. In terms of methamphetamine treatment, their work is useful for reflecting on the political nature of the treatment practices outlined above. My analysis of accounts shows that, like the harm reduction subject interrogated by Moore and Fraser (2006), the subject of treatment is also a figure underpinned by the assumptions of neo-liberalism. The work of Deleuze and STS scholars such as Latour, however, allows me to address Moore and Fraser’s (2006) concern regarding applying a fragmented subjectivity to an already marginalised population. STS scholars provide us with a way to think about a fragmented or ‘becoming’ subjectivity in a very empirical sense, considering the immediate connections and relationships that constitute subjects. Using this insight, Duff (2014) argues this empirically driven way of considering the world is beneficial to drug use interventions:

The best research, the best policy advice, and the best harm reduction praxis never ceases to concern itself with the real conditions of consumption; with the specific circumstances in which bodies, spaces and substances interact in the event of AOD use (see Fraser & Moore, 2011). As such, harm reduction ought to focus on the assemblage rather than structure or context in its consideration of a means of intervening in events of AOD use. (p. 638)

Thus, while subjects that emerge from assemblages are always ‘becoming’ — at the same time, consideration is given to the real conditions of drug use and the relationships and connections that capacitate these subjects. In terms of treated bodies, this enables a focus on the resources that they are connected with. Thus, the subjects that emerge from assemblage thinking *are* fragmented and non-rational. But focusing on these subjects in terms of their relationships to materiality and how these relationships produce their drug consumption — problematic or otherwise — shows that attributes such as rationality can emerge from particular relationships, and that change is dependent on shifting relationship and connections. Like Moore and Fraser (2006) I am not proposing a correct way to define drug-user subjectivity; I do hope, however, to propose that there are alternative, empirically-based and pragmatic ways to strategically address the treated subject.

### **Resisting and rejecting change**

While client change was a central concept in accounts of service provision, other accounts rejected or subverted the need for it. These accounts were provided by workers who did not work with people specifically using methamphetamine but at general AOD services. This section features practices that enact unchanging clients, how these relate to the absolutes by which we understand drug use and the specific ‘set[s] of tensions’ (Mol & Law, 2004, p. 58) that may arise. Generally, treated bodies were enacted as unchanging for three reasons. First, clients were not considered capable of change (and harm reduction and/or treatment services therefore provided ‘respite’). Second, change was considered an almost unpredictable outcome and not specifically the result of client capacity. Third, clients were viewed as part of a wider social and economic environment, where elements of this environment were considered as requiring change rather than the individual client. The discussion that follows considers these three ways of mobilising change.

### **Unchangeable bodies**

Several accounts enacted an unchangeable drug-using body. In some cases this was done through the practice of ‘respite’. This practice does not require change; rather a person is

cared for and kept comfortable for a period of time. The practice of respite was evident in service provision accounts from inpatient withdrawal services and primary health care facilities. Yvette, for instance, a worker at an inpatient withdrawal unit, stated that she thought the goal of abstinence was, for many clients, unrealistic. She thought that there were 'honest' clients who admitted from the outset that they were accessing the service as a kind of respite. Yvette said of these clients:

They'll say 'Oh I've just come in for a break', you know, and it's just a way of harm minimisation, call it what you like, but you know, the ones that are honest.

With this statement, Yvette legitimised the goal of taking a break from drug use (rather than wanting to cease drug use altogether) through labelling it 'harm minimisation' and by suggesting that in many cases abstinence is unrealistic.

Yvette's account enacted an unchanging treated body through acknowledging the enormity of change required if a client were to become abstinent. She stated:

[The] reality is, I think it's hard to give it all up at once. You get people who come in, and they want to get off cigarettes and everything, they're just not realistic at all. I mean, four litres of wine a day, they want to come off that, they want to come off cigarettes and they want to also come off maybe valium they're prescribed, just do it all at once. In one week you can only do so much.

Here, Yvette explains the unchangeable body through describing the sheer amount of substances and practices to be given up if clients were to become abstinent at the cessation of treatment. She is also cognisant of the limitations of her practice and what is possible in the space of just one week. Thus, while accepting that her practice is in many cases respite, Yvette enacts this as a legitimate harm reduction measure. Moreover, while her clients emerge from practice as unchangeable, they do so because of their relationship to multiple substances, and as a limitation of practice rather than due to personal failings.

Katrina, a nurse employed at the same inpatient withdrawal unit as Yvette, also noted the limitations of what was possible in practice in terms of change, but talked about this in broader terms than people's substance use. She explained that clients accessing the service come with:

a whole gamut of different sorts of situations....It can be overwhelming just one of them, although they have six or seven different things.

Like Yvette, Katrina said that clients might expect outcomes beyond what was possible

through attending an inpatient withdrawal unit:

It's sort of looking at trying to bring it into perspective of what's do-able and the timelines, because everyone sometimes might want to do everything all at once, and that's part of their chaos; that they can't do anything, yet they want to do everything all at once.

Her practice focused on addressing what was possible given the service constraints of the withdrawal unit:

So it's trying to sort of bring back the timelines into what's achievable over a short sort of period of time, and have some sort of sense of what supports are available, but sort of looking at, let's just do this in increments. And even sort of starting with just getting up in the morning and having a sense of, you know, breakfast, lunch and dinner, socialising with other people, having a routine of the groups and attending that and being on time, and just that sort of sense.

Katrina's focus on the possible is pragmatic, yet also enacts a childlike client; one that is 'chaotic' and 'can't do anything' and needs to learn the most basic skills such as when to wake and eat. This is, however, the nature of practice within many inpatient withdrawal units. These are services where time and space are highly regulated phenomena. Katrina views this as a necessary response to the 'chaos' of people's lives and of people themselves. Yet the need for time and space to be tightly ordered is also conducive to maintaining control of a group of individuals unknown to each other, within a confined space, and often experiencing physical, social and emotional discomfort. Nonetheless, while Katrina understands aspects of her clients as chaotic, her practice of addressing what might appear as insurmountable issues incrementally suggests a commitment to address and respond to some of the issues faced by her clients such as homelessness, employment and family and legal issues.

Client accounts from the inpatient withdrawal service at which Yvette and Katrina worked supported their assertion that some people entered the service with very high expectations of change. William, for instance, a 42 year old unemployed truck driver (introduced earlier), had been using cannabis, methamphetamine and alcohol daily. As he stated:

I'm trying to kick everything, like yeah, the drink, the smoke, the ice, yeah, speed. I'm trying to do it all at once so because I see, if I'm on one, I'll be on the other. It's just sort of a habit to me. So yeah, I'm here, trying to give it a shot, to give everything up.

William knew this would not be easy:

The next day — that will really start to test me I think, with the withdrawals, so — but at the moment, I don't feel too bad — a little bit anxious, yeah, of what's going to happen, but I'm feeling positive.

William had used a combination of drugs daily for around 25 years. He had taken drugs while working, as well as at home, where he had set up an area in his outside shed exclusively for smoking ice and cannabis. These practices of drug use, where drug consumption was part of both his work and home life, a daily activity and one given a specific space in his home, would presumably be difficult to disengage from. It therefore seems unlikely that, despite wanting to be abstinent, William would achieve this goal as a result of a seven-day stay at an inpatient withdrawal service.

Other clients of the service expressed the treatment outcome they wanted in broader terms than drug use. Kate, aged 39 (introduced earlier), said of her stay at the inpatient withdrawal service:

It's the start to a new life. I get clean, I can think clearly, I focus more and I know what I want in life.

Here Kate assumes she will be 'clean' (or abstinent) and begin 'a new life' upon leaving the service. She also stated that she would know what she wants once she is abstinent, drawing upon an addicted/non-addicted binary to understand her clean body as one that can 'think clearly', 'focus' and 'want' the right things. Peter, aged 35 years, similarly felt that the inpatient withdrawal service would result in life changes for him. After treatment he aimed to get custody of his son, repair his relationship with his partner and stop smoking methamphetamine and cannabis. When asked about his goals for treatment, he said:

To work on getting my boy back, to work with DHS,<sup>20</sup> to get married and having another little baby and yeah just be a happy family and do the things that like what you or, you and your partner, all go shopping, go for tea, or you know what I mean, like 'sorry we can't go out for tea tonight because I just spent me money on pot'.

Like Kate, Peter believed he would cease using drugs after leaving the service and, as a result, his life would change: he would have access to 'normal' activities such as marriage, shopping and eating out.

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<sup>20</sup> DHS is the Department of Human Services (Victoria) — the state government department that Peter was dealing with regarding child custody.

It is easy to understand why these client goals seem unrealistic, or even disingenuous. William had a long history of drug use and it seemed unlikely this would cease after spending seven days in an inpatient withdrawal unit. Kate and Peter were both recipients of government pensions and had limited education and no formal qualifications. Kate lived in a housing estate and Peter was facing a jail sentence. None of these individuals had access to significant social and material resources. Changing their lives significantly would require more than a short stay in a withdrawal unit. Yet, while goals of abstinence and a start to a new life could be interpreted as platitudes or as wildly unrealistic, these goals also suggest a desire for a better life, one free from the social and economic instability that these individuals experienced.

The incongruence between the possibilities of treatment and the expectations and desires of clients illustrates a shifting set of tensions. Many people enter treatment with the expectation of change; however, the change they desire is far greater than merely modifying their drug use. Given the circumstances of many clients that access publicly funded treatment, how are workers to be mindful of the difficulty of disentangling their clients from networks of poverty and social isolation, without succumbing to paralysis in the face of what might appear to be unchangeable? The hazards of this are evident in Robert's account. As Robert (a mental health worker at a primary health care service) said of his work:

Some people that we see at our service are like bottomless pits, they need so much support and so much help and we can only do so much. But even if I was to spend, or anyone was to spend, 10 hours a day with them, seven days a week, they still would only get so far.

Here, some clients' needs are enacted as so great that the process of change is impossible, as no worker could provide the level of service Robert asserted is required to 'only get so far'. Through this statement Robert describes the many problems that his clients face and, correspondingly, the high level of support they need. But in doing so, he risks evoking unchangeable clients as immutable objects of hopelessness, as 'bottomless pits'.

A political effect of enacting drug-using bodies as unchangeable is that efforts at intervention to enable change are negated. If these bodies are incapable of change then there is no obligation to address the social and economic marginalisation they may experience; they are inherently 'drug' bodies and beyond assistance. This suggests that while it is important to recognise the limitations of harm reduction and/or treatment practice, it is also important to

bear in mind that these practices can play a role in addressing the broader circumstances of clients. Harm reduction and drug treatment practices involved helping clients to find housing, deal with family issues such as child custody and so on. As such, practices that are cognisant of the social and economic status of clients, and that attempt to address incrementally some of the issues faced by clients (drug use or otherwise), seem pragmatic and useful; an attempt to improve the client's lived experience within the limitations of what is possible.

### **Change by chance**

While change was enacted in accounts as linked to individual agency, there were also accounts in which change was considered almost arbitrary, or at least as a process that was separate to practice, and perhaps even to the capacity of the individual. Katrina, a worker at an inpatient withdrawal service, was explicit about the sometimes arbitrary nature of change, and also saw change in a broader sense than as only relating to the actions of individuals.

When asked why some people might succeed in stopping their drug use, she stated:

There's a variety of things. It might be chance, it might be being in the right place at the right time, hearing whatever's said, and then actually listening to what is being said in a different way. You know, it might be someone sort of just having faith in them, having some sort of hope in their own ability to make changes. I think there's a whole gamut of different sorts of things, but it's looking at what's important, you know, that person's beliefs and values and um, seeing what's important to them, rather than what you think's important, and trying to change them for the sake of changing. I don't know, just seeing what sort of benefit people get out of their dependency, and looking at why they're wanting to make changes, and if there is ambivalence.

Here, Katrina moves between offering an agentic account of change (referring to people's ability to make changes) and suggesting change might occur by 'chance' or by 'being in the right place at the right time'. Katrina notes that some people might not need to be changed as they get benefits from their 'dependency'. She warns against change 'for the sake of changing' and (similar to her colleague, Yvette) legitimises the practice of respite for those who do not seek change. She also refers to a 'whole gamut of different sorts of things' that might contribute to change; this evokes a reality where clients are engaged in multiple encounters and assemblages related to drug use. Considered this way, service encounters such as treatment are part of myriad assemblages, and may contribute to mitigation of drug-related harm and drug use, dependent on the other encounters in which people are engaged.

Katrina's account of practice subverts neo-liberal interpretations of change. In her account change is not expressly the result of individual agency, or a corollary of practice; it may be arbitrary. However, this is different from Robert's enactment of some clients as unchangeable, thereby negating the role of harm reduction and treatment services. Katrina's account of service encounters, clients and change is not diminishing of the role of treatment. First, she sees change as possible (although at times incremental). Second, she enacts service encounters as one kind of encounter among many that clients will have. This does not negate or dismiss the possible positive effects of these encounters, but does recognise that other assemblages and encounters in which clients are engaged will mitigate the service encounter. Thus, treatment has purpose, but it is always part of a broader lived experience. Whether an individual has housing, whether they have employment or parental obligations — all the other assemblages and identities in their lives — contribute to the enactment of the treatment encounter.

### **Structural change**

Another way in which change was enacted in accounts of service provision was in relation to broader social and environmental considerations. Liam, a manager at an outreach service, gave an account of service provision that resisted change as related to the capacity of the individual client. His account was not reliant on the centrality of the client to treatment, and instead focused on the lived experience of clients and their social and economic disadvantage. He stated that at his service:

We work very strongly from a sense of social justice and sort of saying the world is not an equal place, and that this particular group of young people who we target are often quite marginalised, disadvantaged and not connected with the community. And so again, we work very much in the framework of a social model of health and so all our work is sort of around those risk factors around poor health.

Liam expressly stated that a person did not have to want to change in order to be treated through his service:

Given that our focus is on health and well-being, it's not like you're going to have to want to change...like you're going to have to stop using.

The object of treatment or intervention, then, was the client's health and well-being, and this was not only linked to their drug use. In Liam's account, clients were not required to change because their poor health and need for support was assumed to be the result of inequality and



disadvantage, rather than their individual limitations. It was not the individual that needed to change in order for their circumstances to improve, but wider considerations such as their access to economic and social stability. Thus, Liam employed the concept of change in his practice, but in a broader sense than individual change. As he explained:

I have a very strong belief that we don't have a fair or equal society and I have a very strong belief that we should try to basically... there's a whole lot of social determinants that go into people's health... especially because I don't see biological factors why everyone has to have differences, we can change this stuff.

Here, clients are embodied within and through their environments. Moreover, these environments are considered to be productive of the harmful living circumstances of clients and, in this way, Liam's account resists the centrality of client change to practice and to the problem of drug use.

In enacting change in a broad sense, however, tensions arise between practice and policy and funding bodies, as these produce the concept of change in a narrow sense. As Liam stated:

Our work has to be accounted for by significant treatment goals. So we've got targets. That in itself is a bit of a flawed system. We have to do a certain amount of work with people and because it is very hard to be tangible around that kind of work, what we have to do is we have to sort of say, we have to actually sort of meet a certain amount of episodes of care. It means that we have to get a significant treatment goal. Those significant treatment goals are actually fairly wishy-washy and that suits us because it means — the last thing we want to suggest is that we're not accountable, we're happy for our work to be scrutinised, absolutely we just don't always agree on what measures should be — I would argue that for a 17, 18-year-old that given things like the social model of health for instance, that simply looking at someone's end product of drug use, whether it reduces or not, is not necessarily the only factor.

This statement demonstrates how treatment practice is shaped by the assemblages of government. The targets and goals produced through these assemblages ensure that individual change is central to the provision of service to people who use drugs. Liam characterised the actual targets that must be met as 'wishy-washy' but suggested that this is helpful in making his actual practice fit with the prescribed episodes of care model. However, he also suggests that the way in which treatment is funded and assessed others pressing issues that people

using drugs often face — such as a lack of housing and financial insecurity — through the need to meet targets and goals.

While client change was enacted in many service provider accounts as central to harm reduction and/or treatment practice, this concept was resisted or subverted in other accounts. These interventions led to their own particular set of tensions. In accounts where change was not required, there was the risk that clients were materialised as unchangeable, and responsibility for the social and economic marginalisation they experience was alleviated for treatment providers. Change was also subverted, enacted as arbitrary and as part of a ‘whole gamut’ of different things. This is potentially confronting in that it could be interpreted as negating treatment practice. Yet, it also creates an opportunity for the practitioner to be mindful of the many encounters in which their clients are engaged, and that these all play a role in their drug use experiences. Lastly, for practitioners attempting to enact change as a broader phenomenon, tensions arise between practice and the ways in which the assemblages of funding and policy shape harm reduction and/or treatment practice.

## **Conclusion**

In this chapter I have analysed accounts of methamphetamine-related service provision in order to illuminate the ways dominant understandings of this drug and its consumers shape practice. My analysis addressed the ontological contingency of treated bodies, showing how dominant figures such as the neo-liberal subject and the absolutes of drug use are embraced and resisted in their constitution. While attending to the specificity of methamphetamine through exploring accounts of practice at a stimulant-only service, I have also necessarily looked at service provision in AOD more broadly, as most AOD services are accessed by people using a range of drugs. Nonetheless, accounts, whether methamphetamine-specific or not, reveal the ways in which the treatment practices made available to methamphetamine and other drug users are shaped by the broader conditions of possibility, and are inherently political.

I addressed accounts of service provision through tracing the ways in which change is conceptualised in accounts, and how this might result in various sets of tension. While accounts produce conventional understandings of change, such as locating the capacity for change within the individual, accounts also resisted and complicated this conceptualisation of change. These accounts posit that change *may* occur, change *may* be unrelated to treatment practices, and change should be considered in a broader sense rather than at individual level.

Tensions arose when service practices that assumed a neo-liberal subject ignored the networks and assemblages through which individuals embodied themselves. For those people enmeshed within networks delineated by their lack of material, economic and social resources, this was problematic as their circumstances were then considered the result of choices or priorities. Conversely, those people with access to the resources needed to emulate the neo-liberal citizen found it difficult to reconcile the way they embodied themselves with the figure of the drug-using subject. While there were efforts to address this discrepancy, it raises the question as to why anyone accessing drug services should have to identify with this particular compulsive and addicted subject.

Less conventional understandings of change also introduced tensions. The practice of respite was considered a legitimate response to drug use. Enacting clients as bodies in need of respite takes into account their marginalisation and lack of significant social and economic resources. Yet, while it is important to acknowledge the social and economic marginalisation of clients, this should not lead to them being materialised as unchangeable, as immutable bodies. This might lead to inaction in terms of addressing this significant level of marginalisation. For some service providers addressing the significant challenges clients faced in finding housing, employment and so on were best addressed incrementally, acknowledging that the support required was beyond what the service could offer. Some service providers sought to enact change in a broader sense in their practice, by acknowledging that environmental aspects may produce the health, social and financial problems experienced by their clients, however, tensions arose when this practice was required to fit the assemblages of policy and funding. Finally, there were service providers who, in order to understand change in the lives of clients, conceived of service encounters as simply one of many encounters that will produce and/or mitigate a person's drug use.

These accounts also show the specificity of methamphetamine-related treatment practice. The stimulant-only service effectively offered CBT, with some adjunct services. This was unique to this service. These practices enacted a hyper-knowledgeable, self-controlled and reflective client, similar to the treatment literature reviewed in Chapter 5. And yet clients of this service had additional mental health problems (including psychosis) and used a drug inscribed with destructive and addictive properties. This finding suggests the contingency of knowledge around drug use — that we can understand some 'destructive' drugs as treatable through modes emphasising an active subject (methamphetamine) and others as not (heroin). It also shows the performativity of practice, and how different treatment assemblages capacitate

individuals in different ways. Most importantly, it shows how access to resources such as education, income, housing and so on enable people to make choices about their drug use, suggesting the ongoing need to remain cognisant of the many elements that enhance a person's capacity for change.

In the conclusion that follows, I bring together the themes of the previous chapters — the constitution of the substance 'methamphetamine', the extreme absolutes of methamphetamine use as they are produced and reproduced through policy, treatment and media texts, and the ways in which these are embraced, resisted or subverted in accounts of methamphetamine use and service provision — in order to make some final comments with respect to the ontological politics of methamphetamine.

## Chapter 8: Conclusion

Methamphetamine is a drug that continues to receive significant scientific, policy, treatment and media attention. In this thesis I provide an analysis of this attention informed by two related research questions. First, how are methamphetamine and methamphetamine consumers constituted in scientific, policy, treatment and media discourse? Second, how do consumers and service providers draw upon, reject and subvert authoritative discourse through consumption and harm reduction/treatment practices? To address these research questions I investigated the material—semiotic relations of methamphetamine. I traced the enactments of methamphetamine and methamphetamine-using subjects in scientific, policy, treatment and media discourse, showing their political effects and specificity. I then examined accounts of methamphetamine consumption and service provision, describing how individuals draw upon these enactments, embracing, resisting or subverting them, in order to constitute themselves — and the object ‘methamphetamine’ — in multiple ways. My key concern in this exercise was to make visible the ontological politics of methamphetamine, illuminating the open and contested nature of realities. In doing so, I sought to disrupt the dominant ways in which we know methamphetamine and methamphetamine users. Moreover, I have shown that the very limited ways of constituting methamphetamine and methamphetamine users result in the further pathologisation and marginalisation of people who use this drug.

This research was theoretically driven by the work of Gilles Deleuze and Michel Foucault, and STS scholars Bruno Latour, John Law and Annemarie Mol. These scholars provide concepts that illuminate the contingency of realities — revealing how these are shaped through localised networks of practice, as well as hegemonic ideals. Employing these concepts, I have foregrounded the performativity of methamphetamine-related *practice*. I showed how localised methamphetamine-related practices are produced by, and are productive of, the subjects, objects and spaces of drug consumption and drug service provision. Further, I have argued that while the assemblages of drug consumption and service provision enact a multiplicity of phenomena, these have common features due to the overarching discourses and practices that constitute a Euro-American ‘reality’ (Law, 2004; Mol, 1999). These common features include the valorisation of choice and autonomy, and fear and disgust of the addicted subject.

Drawing on the work of post-structuralism and STS entailed a methodological approach that could address a multiple and inherently political reality. Thus, in order to carry out my

research, I employed a method assemblage approach. This methodological arrangement addresses an ‘interactive, remade, indefinite and multiple’ world (Law, 2004, p. 122). It is an approach that assumes that research practice performs ‘truths and non-truths, realities and non-realities, presences and absences’ (Law, 2004, p. 143). In this sense, method assemblage is unavoidably political. It obliges the researcher to be cognisant and reflective of practice, being aware of the objects, subjects, practices and spaces that are constituted through method. It is also a commitment to enacting realities that are less oppressive — ‘to make some realities realer, others less so’ (Law, 2004, p. 67).

As detailed earlier in this thesis, a range of scholarly work uses post-structuralism and STS to address drug consumption, harm reduction and treatment. I have taken up some of the insights generated from this work to interrogate methamphetamine consumption and related service provision. This is an area worthy of critical attention. As I have shown in this thesis dominant discourses constitute methamphetamine users as specifically violent and psychotic and methamphetamine as a uniquely toxic drug. Government and policymakers continue to problematise this drug, while the media enacts users as grotesque figures. These discourses hence problematise methamphetamine and further pathologise and marginalise users of this drug. My research builds upon the existing literature to disrupt these extremely pejorative enactments, making visible more nuanced and complex but less oppressive realities. This is significant as more complex readings of drug use enable us to understand it as a practice undertaken for reasons other than compulsion — such as pleasure, desire, functionality, control and wakefulness. It allows us to consider this practice as one of many an individual may undertake, and one that is not inherently harmful. Moreover, it requires us to conceive of the outcomes of drug use (harmful or otherwise) as constituted by myriad aspects, not simply the purported pharmaceutical properties of a drug and actions of the drug user.

In addition to providing a complex account of methamphetamine use and service provision, my research augments critical accounts of drug use more broadly, as it foregrounds the ontological possibilities of drug use and harm reduction/treatment assemblages. This means that I show how the many forces, spaces, objects and subjects of drug use come together to constitute methamphetamine and methamphetamine users. This empirically driven way of attending to methamphetamine moves beyond accounts of drug use which conceive of drugs and drug users as pre-existing phenomena (with reified properties), interacting within pre-existing contexts. Instead, I show the dynamic nature of the connections and relationships people can form and how these capacitate individuals as well as shape the materiality of

methamphetamine itself. This attends to the political nature of all things — never assuming any substance or identity is a true representation of reality. It thus opens up a wider range of possibilities for understanding drug use and drug users, beyond that of traumatised, violent and psychotic individuals interacting with toxic substances. Further, considering all elements of drug use as enmeshed within and produced through assemblages provides an empirically robust method of tracing ‘an array of agents active in any instance of AOD use’ (Duff, 2012, p. 155). This contributes to an alternative body of knowledge that addresses methamphetamine consumption in ways that are not driven by the need to intervene on pathologised and/or deviant subjects.

In this conclusion, I draw together the themes explored in this thesis, considering the boundaries that I have enacted — that is, what has been made present in the course of this research.

### **Methamphetamine as a matter of fact**

I have shown how the substance ‘methamphetamine’ — particularly in the form of ice — is reified in dominant discourses in Australia as a uniquely addictive and destructive drug. One of the purposes of my research has been to disrupt such claims. In order to illuminate the ontological contingency of methamphetamine, I examined its constitution in the field of science. While an existing body of literature critiques the construction of methamphetamine ‘panics’ (see Chapter 2), this work assumes methamphetamine is an ontologically stable substance. The ‘panic’ argument is that the pre-existing object ‘methamphetamine’ has been misrepresented by fields of knowledge such as the media and policy, and a problem — or panic — is constructed in these particular domains. It is, however, assumed that domains such as science, public health and biomedicine are true representations of reality — incontestable fields of knowledge — and these domains are used to assert the *real* scale of the methamphetamine problem.

My research differs from these accounts by addressing methamphetamine as a multiple substance with contestable material properties. It is thus made and re-made through practice — including scientific practice. I argue that science (like any other body of knowledge) is a form of craftwork, and trace the ways in which methamphetamine is enacted in scientific texts. I find that these texts are not descriptions of the pre-existing substance ‘methamphetamine’ but, through literary inscription, enact this substance as specifically potent and its users as uniquely violent and psychotic ( see Chapters 4 and 5). I posit that

scientific practices and devices can only ever inscribe illicit drugs in particular ways as they are embedded in existing hinterlands such as biomedicine and addiction studies. Within these hinterlands, established inscription devices, such as the SDS, can be referenced and adapted in order to ‘make’ methamphetamine a drug of addiction. Previously inscribed substances with purportedly similar characteristics, such as amphetamine and cocaine, are also embedded in these hinterlands. This provides an evidence base from which to draw upon to inscribe methamphetamine.

In undertaking this exercise, my aim was not to debunk facts and to assert what methamphetamine actually *is* but to argue that the reification of methamphetamine is a result of particular practices, inscription devices and political choices. While not wishing to deny that people using methamphetamine can experience physical and mental health problems, it is worth questioning the relentless publication of research that inscribes people who use methamphetamine as highly pathologised individuals and the political effects of these activities. How do these ‘facts’ about methamphetamine-using individuals affect their lives? Do they make a positive difference, or do they contribute to broader discourses that problematise and further marginalise this group? Can the lived experience of people using methamphetamine be researched without relying on diagnoses that further pathologise and marginalise this group?

In responding to these questions I followed Latour’s (2004) suggestion that, rather than hastily inscribing materiality through the creation of ‘facts’, we should consider phenomena as ‘matters of concern’. This does not mean rejecting scientific knowledge but acknowledging its limitations and political effects, and expanding upon it through a renewed form of empiricism. Drawing on Latour’s argument, my research acknowledges the multiplicity of the substance methamphetamine: that it can be a drug of harm, but also a drug of pleasure; that it can be associated with violence but also with work, sport or ‘normality’. Researching methamphetamine as a matter of concern and empirical focus required opening up the study of drug use to consider the assemblages of objects, subjects and spaces that come together to enact drug use, making visible specific networks and assemblages of drug use and drug harm reduction/treatment. I now discuss my analysis of the ‘absolutes’ of methamphetamine use and then present some concluding remarks about how these absolutes shape the assemblages of methamphetamine use.



## **Methamphetamine-using subjects: ‘Hyper’ absolutes**

In this thesis I have argued that policy, treatment and media texts constitute methamphetamine users in binaries. As illustrated in Chapter 5, this reflects the work of other scholars who have exposed the binaries that enact drug use in modern Western thought such as voluntariness/compulsivity, controlled/chaotic and addict/abstinence. Building on the work of these scholars I have exposed the specificity of methamphetamine, arguing that methamphetamine-using subjects are enacted in ‘hyper’ absolutes. Further, I have extended the concept of absolutes, describing their ontological implications — how they shape methamphetamine-related practices. In this section I discuss some of the key points I raised in my analysis of methamphetamine-using ‘bodies’.

My analysis of authoritative texts argued that a hyper-knowledgeable, choice-making, methamphetamine-using subject is constituted through harm reduction practices and highly active treatment practices such as CBT and self-help. These practices are shaped by neo-liberal health care systems, where citizens are obliged to access and use information in the interests of their own health. However, they are also shaped by the way methamphetamine has been inscribed as psycho-socially addictive rather than physically addictive, unlike the inscription of heroin. The psycho-social nature of methamphetamine addiction has led to methamphetamine-using subjects being obliged to work upon themselves in order to address their behaviour and related psychological disorders such as depression and anxiety. As such, methamphetamine treatment practices are very different from the dominant treatment practice for heroin — OST — which does not oblige individuals to acknowledge or address their psychological state, but are required instead to attend a dispensing point each day to consume a drug under supervision. These two treatment subjects are binary opposites: the methamphetamine-treated subject is active and reflective while the heroin-treated subject is supervised and drugged. And yet, in spite of the enactment of methamphetamine addiction as a psycho-social phenomenon, there remains a desire to discover an appropriate pharmaceutical to treat methamphetamine use. Perhaps a discovery in this area would allow us to shape methamphetamine treatment practices in a more familiar way, by foregrounding the physicality of addiction (Keane, 2012). By revealing the various ways we understand addiction, I have not argued for the merits of different types of treatment. Rather, I have shown how treatment practices are political, shaped and constituted by a range of phenomena — including broader understandings of the self and available pharmacology — and how these practices, in turn, enact particular types of treated bodies.

Another aspect of the knowledgeable and controlled methamphetamine-using subject that I have sought to highlight in my research is that it is a paradoxical figure. Although this subject is highly agentic, the inscribed properties of methamphetamine (potent and addictive), require that methamphetamine-using subjects are always at risk of addiction and chaos. Making present this paradox led to the more familiar manifestation of the addicted and chaotic methamphetamine-using subject. In the case of methamphetamine, this subject features prominently in the media, but is also visible as a non-compliant, anxious, psychotic and violent figure in policy and treatment texts. Like the hyper-controlled methamphetamine-using body, this subject is also extreme. Methamphetamine-using bodies (particularly ice-using bodies) are constituted as more ‘hardcore’ and more prone to violence and psychosis than other drug-using bodies (see Chapter 5). I therefore argue that we understand methamphetamine-using bodies as both uniquely controlled and functional, and as uniquely without control and chaotic. This reveals the contradictions inherent in the practices that surround methamphetamine consumption and service provision and the limited understanding provided by the absolutes of drug use. The very different treatment practices and expectations of users of heroin, another ‘destructive’ drug, further demonstrate the contingency of knowledge around drug use.

Interrogating the binary spheres of methamphetamine-using subjects made visible the political effects of understanding methamphetamine use in this way. Most significantly, binaries such as voluntariness/compulsivity locate agency within the individual, thus responsabilising drug-using subjects (Rose, 1999). The practices and assumptions that enact knowledgeable and reflective subjects — such as CBT and self-help — ‘other’ the assemblages of drug use and the circumstances of people who use drugs that, in turn, shape their capacity to ‘choose’ or to change their drug use. The assumption is that individuals make unhindered choices and are thus responsible for the outcomes of these choices. This is problematic, particularly for those individuals enmeshed within assemblages characterised by social and economic deprivation who, because of these specific assemblages, are less able to ‘choose’ employment, safe housing, higher education and so on. Thus, a political implication of responsabilising drug-using subjects is that those without access and linkages to resources that enable them to make health-orientated choices are held to be responsible for their status.

By showing the limitations and political effects of the binaries that underpin drug use, I have argued this is a problematic and inadequate way to frame drug use. In response to these

limited understandings of drug use, I have made visible the ways in which the assemblages of drug use capacitate individuals, enacting multiple subjectivities and objects — including methamphetamine. In the following section I sum up my arguments concerning the assemblages of methamphetamine consumption and treatment.

### **Drug consumption assemblages**

One key challenge in researching methamphetamine use was how to describe practice in ways that could do justice to shifting and multiple versions of reality. This required a methodological commitment to look beyond the individual drug user to the material—semiotic networks in which they were enmeshed — using ‘assemblage thinking’ (Duff, 2014, p. 633). As I noted in Chapter 2, scholars in this area have previously used this way of thinking to good effect. However, my research represents a novel application of this concept as I apply it to disrupt the absolutes of methamphetamine use. That is, I use assemblage thinking to show how attributes such as ‘controlled’ and ‘uncontrolled’ are produced through the connections and relationships individuals form within discrete assemblages. I thus argue these assemblages have ontological implications — ‘making’ controlled individuals, rather than this being an inherent personal quality. This is an exercise not previously undertaken in the literature. It is, however, a significant analysis as it spotlights the political effects of the way methamphetamine users are currently constituted, showing that they are specifically constituted as hyper-controlled and, at the same time, hyper-chaotic. Moreover, by focusing on assemblages my research contributes to a body of work that is able to challenge common assumptions about drugs and drug users — that drugs are inherently toxic, and that drug users are compulsive and chaotic beings. One of the ways I do this is to argue that drug assemblages capacitate bodies in particular ways. Thus the binaries of drug use practice (such as controlled drug use or chaotic drug use) are not the result of personal failings or strengths but are produced through the various material—semiotic networks individuals are enmeshed within.

Employing assemblage thinking entailed moving beyond broad, structuralist concepts such as class as explanatory tools. At the same time, it was necessary to spotlight the power arrangements of assemblages in order to demonstrate the ways in which power shapes and constrains the lives of individuals, and to show the links between agency and power, and access to economic and social resources. Methamphetamine-using participants were not a homogenous group with respect to their access to these resources. Some were unemployed, and as a result had very low incomes. Some participants had well-paying professional jobs.

Some participants were homeless while others were home owners. Some participants had very strong connections to their families, with a sense of obligation towards them, whereas others were estranged from their families. By describing the drug-using assemblages people were enmeshed within, I sought to illustrate how these connections and relationships are productive of the ways people constituted themselves and their drug use. I argued that the assemblages of methamphetamine consumption showed that the connections and relationships individuals formed were productive of specific capacities. For instance, individuals who embodied themselves as highly knowledgeable about methamphetamine and brain chemistry had ready access to education and tools such as computers. Individuals who felt powerless over methamphetamine or ‘taken over’ by this drug were enmeshed within networks characterised by a lack of access to significant social and economic resources, and thus were typically constrained in the choices they could make.

While I sought to interrogate the absolutes of methamphetamine-using subjects, revealing their slippages, inconsistencies and limitations, it was apparent that participants drew upon these binaries and other dominant ideas of drug use in order understand themselves and their methamphetamine consumption. All of the people interviewed for my research constituted themselves as addicted or as having an ‘addictive personality’, thus embodying themselves as compulsive drug users. The prominence of addiction in accounts reflects the authoritative status of the concept in Western liberal societies: ‘addiction’ is used to describe any allegedly compulsive practice and *any* practice can be labelled compulsive. If addiction to anything is possible, the word’s negative connotations are diminished; however, when applied to drugs — particularly ice and heroin — the term ‘addict’ evokes a very specific, out-of-control, immoral, hopeless and repugnant subject.

In this research, I have outlined the ways in which individuals draw upon dominant discourses to constitute agency and drug use. However, I also argue that participants subverted and resisted these discourses in methamphetamine consumption and service provision practice. For instance, people using methamphetamine compulsively also engaged in consumption practices that were highly agentic. Thus, while embodying themselves as addicts, they could still display the attributes of a highly in-control individual. This suggests that powerful discourses limit and shape the ways we can produce drug use in Western liberal societies, and people using drugs necessarily constitute their practice as addictive. At the same time, their lived experiences complicate the idea of addiction and of agency and drug

use. Further, participants drew upon, but also subverted and resisted, dominant understandings of concepts such as trauma and psychosis. Ice was taken to self-medicate but also to empower the traumatised body. Psychosis was terrifying, but also controlled. In making present some of these complications, I wish to suggest the existence of other narratives that might better describe drug use, narratives in which the figure of the addict does not dominate, but instead give attention to the many forces that contribute to drug use and its myriad forms.

### **Harm reduction/treatment assemblages and change**

In addition to exploring methamphetamine consumption, I examined the absolutes of drug use through harm reduction and/or treatment practices. As I have noted previously, methamphetamine service provision has received little theoretical attention. Through my analysis of this area, I provide new insight into the specificity of treatment for methamphetamine use. I also contribute to the literature more broadly as I describe the ontological implications of treatment and harm reduction practice. Building upon insights offered by scholars such as Moore and Fraser (2006) concerning the drug-using subject, I have illuminated the ways in which practices of service provision capacitate subjects in different ways.

I analysed a range of accounts of harm reduction and/or treatment practices, showing how these practices oblige bodies to constitute themselves in specific ways and exploring some of the political effects of these embodiments. I noted the specificity of methamphetamine specialist treatment — a set of treatment practices that embodied individuals as highly knowledgeable and ‘active’. I also foregrounded the concepts of change in these accounts, using the different ways in which practitioners deployed this concept in order to further examine the binaries that underpin drug use. Conventional understandings of change articulated by practitioners were made present, as were accounts that subverted and/or resisted the concept of change. It was also evident that the political effects of these conceptualisations of change were dependent upon the resources to which individuals in treatment had access and could connect. For instance, some people accessing treatment embraced the idea of change as resulting from individual capacity and saw themselves as active in their treatment — and thus were able to instigate change. In turn, the assemblages and provider practices that enabled them to embody themselves in this way implied that change is inherent in the individual, and as something that could come from the techniques taught as part of treatment practice.

However, while it was possible and desirable for some individuals to embrace change and to embody themselves as active treated subjects, for others this proved more problematic. Change was also required of individuals who were enmeshed within assemblages characterised by a lack of economic and social resources. In doing so these assemblages were othered, and if people did not change they were seen as not prioritising correctly or as unwilling to change. Thus, enacting people who use drugs as inherently capable of change can obscure their lived experience — one that might be characterised by very limited access to social and material resources, thereby limiting their capacity to change. I also noted that assemblage thinking enables moving beyond the ‘change-ready’ subject; that is, subjects could be considered in terms of their immediate connections and relationships to social and material resources, and their capacity to change seen as being produced through these connections, rather than through inherent individual attributes.

Another significant way of thinking about change made visible by this research — and one that challenges more conventional understandings of the change concept — is where change is conceptualised as unnecessary or as unpredictable. These practices constituted clients in different ways and with different outcomes. First, they could enact clients as beyond change, immutable and non-agentive, with the political effect of negating the need for intervention, assistance or support to people who use drugs. However, these practices might also enact clients as in need of respite — requiring that service providers were first and foremost pragmatic, addressing clients’ immediate needs without the expectation of change. Harm reduction and/or treatment practices also constituted clients as changeable, but with change emerging not solely as the result of service encounters. Such practice recognised that the service encounter could be one of many encounters that might mitigate or change drug use. Finally, I also revealed how change was conceptualised in a very broad way, without the onus being on the client to change. This was the expectation that clients’ lives would improve with social and environmental change, but these practices were constrained by the assemblages of policy and funding in which certain institutional and bureaucratic requirements valorised individual change.

## **Summary**

In illuminating the ontological politics of methamphetamine and the contested nature of realities, my research was guided by two main research questions. First, I traced the dominant enactments of methamphetamine and methamphetamine-using bodies in authoritative fields such as science, policy, treatment and media. In these fields, methamphetamine is enacted as

a uniquely potent and addictive drug, and methamphetamine-using bodies are materialised in hyper-absolutes. On the one hand they are highly knowledgeable, controlled, choice-making subjects; on the other, they are psychotic, chaotic and violent — ‘worse’ than heroin users. Second, drawing on accounts of consumption and service provision, I illustrated multiple enactments of methamphetamine and methamphetamine-using bodies; this allowed me to illuminate the ways that consumers and harm reduction/treatment practitioners draw upon, subvert and resist hegemonic enactments of methamphetamine and methamphetamine users. It showed the multiplicity and messiness of methamphetamine and its related practices; that this drug can be enacted in many ways — as a drug to handle trauma, as a pick-me-up before work, as one of a series of substances taken on a bender. Moreover, like all individuals, people using methamphetamine are constituted through the desiring forces, connections and relationships to which they have access and which, in turn, form them. These forces, connections and relationships shape drug practices — whether controlled, chaotic or functional — and also shape the available choices. Thus, individuals who use methamphetamine embody themselves through their local assemblages of use, but also draw upon broader understandings of drug use.

My aim was to address methamphetamine consumption as a matter of concern. I have argued that the knowledge around methamphetamine is always contestable and, using empirical methods, I have analysed this knowledge and illuminated its political effects. By assuming the materiality of methamphetamine is contingent, I have provided an alternative account to the very singular and specific way this drug is currently understood in dominant discourse. By treating the assemblages and networks of methamphetamine consumption and harm reduction/treatment as units of study, I have moved beyond the interrogation and description of the methamphetamine-using subject as a way in which to address methamphetamine consumption. Employing these strategies to address methamphetamine consumption has been a political commitment to decentre the drug-using subject. It has also been a means to describe methamphetamine consumption and harm reduction/treatment in complex and nuanced ways, providing an account that does not contribute to the further pathologisation and marginalisation of people who use drugs.

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## Appendix A: Scientific claims about methamphetamine

Table 1 Methamphetamine claims in Australian scientific literature

Claim	Article	Author (year)
<b>Meth/amphetamine is a drug of dependence</b>	Validation of the amphetamine dependence syndrome and the SamDQ	Topp and Mattick, (1997b)
	The applicability of the dependence syndrome to amphetamine	Topp and Darke (1997)
	Choosing a cut-off on the Severity of Dependence Scale (SDS) for amphetamine users	Topp and Mattick, (1997a)
	The relationship between crystalline methamphetamine use and dependence	McKetin et al., (2006a)
<b>Methamphetamine is harmful</b>	'Crystal meth' use among polydrug users in Sydney's dance party subculture: Characteristics, use patterns and associated harms	Degenhardt and Topp, (2003)
	The emergence of potent forms of methamphetamine in Sydney, Australia: A case study of the IDRS as a strategic early warning system.	Topp et al., (2002)
	Major physical and psychological harms of methamphetamine use	Darke et al., (2008)
	Crystal methamphetamine smoking among regular ecstasy users in Australia: increases in use and associations with harm.	Kinner and Degenhardt, (2008)
<b>Crystal methamphetamine ('ice') is more harmful than other forms of methamphetamine</b>	'Crystal meth' use among polydrug users in Sydney's dance party subculture: Characteristics, use patterns and associated harms	Degenhardt and Topp, (2003)
	The emergence of potent forms of methamphetamine in Sydney, Australia: A case study of the IDRS as a strategic early warning system.	Topp et al., (2002)
	The relationship between crystalline methamphetamine use and dependence	McKetin et al., (2006a)
<b>Crystal methamphetamine is more likely to cause dependence than other forms of methamphetamine</b>	The relationship between crystalline methamphetamine use and dependence	McKetin et al., (2006a)
<b>Crystal methamphetamine is not more likely to cause dependence than other forms of methamphetamine</b>	Crystal methamphetamine smoking among regular ecstasy users in Australia: Increases in use and associations with harm	Kinner and Degenhardt, (2008)



<b>Methamphetamine users have higher levels of psychotic symptoms than the broader population</b>	The prevalence of psychotic symptoms among methamphetamine users	McKetin et al., (2006b)
<b>Methamphetamine use is associated with, or related to, violence</b>	Hostility among methamphetamine users experiencing psychotic symptoms	McKetin et al., (2008b)
<b>Methamphetamine can have adverse effects on the cardiovascular system</b>	Cardiotoxicity associated with methamphetamine use and signs of cardiovascular pathology among methamphetamine users	Kaye and McKetin, (2005)
<b>Methamphetamine associated with poor physical health</b>	Impaired physical health among methamphetamine users in comparison with the general population: The role of methamphetamine dependence and opioid use	McKetin et al., (2008a)

## Appendix B: Interview guides

### Interview Guide: Methamphetamine users not using health and treatment services

The interview is likely to take about one hour. I'm going to ask you to read the plain language statement to give you a little bit more detail about my study aims, intended outcomes, your participation and your confidentiality.

Do you have any questions about the research or any of the issues identified in the plain language statement? Do you consent to participate in the study?" [if yes, record oral consent].

#### Quantitative component of the interview:

Age:

Gender:

Australian born:

Permanent resident:

Occupation:

Level of education:                                      Private/public:

Detailed drug use history:

- types of drug used currently
- frequency of use of each drug (daily, weekly, monthly)
- method of ingestion
- age of first use of methamphetamine
- pattern of methamphetamine use (daily, binge etc)
- combinations of typically drug used
- environment drugs used in – street, home or club-based
- drugs taken in the last 28 days.

Detailed health/treatment service history:

- first treatment episode (type, date of entry and length)
- most recent treatment episode (type, date of entry and length)
- most regular form of health/treatment service used
- treatment service used in the last 6 months.

#### Open-ended section of the interviews:

1. Can you describe the last time that you took methamphetamine? How did you take it? What other drugs did you take? Who were you with? Where did you get it from? Where were you? What did you do during and after?
2. Is this the way that you usually take methamphetamine? If not, under what circumstances you would you normally use it?
3. Do you consider yourself a regular or heavy methamphetamine user? Has using methamphetamine made a big difference to your life?
4. Can you tell me why you enjoy taking methamphetamine?

5. Have you experienced any harms or consequences related to your methamphetamine use? Describe these.
6. What are the things that you do to use methamphetamine in safer way – or to reduce your use?
7. Do you feel that you have your meth use under control? Would it be hard for you to stop taking meth?
8. Thinking about the harms that you have mentioned:
- what kind of support would be helpful to you?
  - Is there a health or treatment service that provides that kind of support?
  - Which one/s and why
9. Do you think that you know a lot about methamphetamine and methamphetamine use? Do you need to get information about methamphetamine? What sort of information? Where do you get it from? Has the information you have been able to get been helpful – why/why not?
10. Can you tell me the main reason you have not used a health or treatment service in the last 6 months? Are there any other reasons?
11. Are there issues that are not related to your drug use that affect you being able to use health and treatment services? (eg job, childcare)
12. Can you describe the circumstances (drug use patterns etc) that might lead up to you needing to access health or treatment services? (or describe the lead up to the last time accessed services)
13. Thinking about the last time you entered a health or treatment service for you methamphetamine use, what was the main thing you wanted from the service? Did the service provide this? How/how not?
14. What has been your best experience of health and treatment services (for methamphetamine use)?
15. What has been your worst experience of health and treatment services (for methamphetamine use)?
16. How could health and treatment services change to better respond to methamphetamine use?
17. Can you tell about the role of health/treatment service workers during treatment?
18. Are they helpful to you in getting what you need from the health/treatment service?
19. What qualities do you think are important in the staff that work at health and treatment services?
20. Do you think that methamphetamine is an addictive drug? Why?
21. Are you addicted to methamphetamine? If so, how do you know?
22. Where do you see yourself in 5 years from now – will you still be using?

This interview is about finding out more about methamphetamine users accessing services and how service providers view their role in relation to addressing methamphetamine-related harm. Can you think of anything else along these lines that you think we should know?

Thank you for your time and input.

## **Interview Guide: Methamphetamine users using health and treatment services**

The interview is likely to take about one hour. I'm going to ask you to read the plain language statement to give you a little bit more detail about my study aims, intended outcomes, your participation and your confidentiality.

Do you have any questions about the research or any of the issues identified in the plain language statement? Do you consent to participate in the study?" [if yes, record oral consent].

### **Quantitative component of the interview:**

Age:

Gender:

Australian born:

Permanent resident:

Occupation:

Level of education:

Public/private:

Detailed drug use history:

- types of drug used currently
- frequency of use of each drug (daily, weekly, monthly)
- method of ingestion
- age of first use of MA
- pattern of MA use (daily, binge etc)
- combinations of typically drug used
- environment drugs used in – street, home or club-based

Detailed health/treatment service history:

- first treatment episode (type, date of entry and length)
- most recent treatment episode (type, date of entry and length)
- most regular form of health/treatment service used

### **Open-ended section:**

1. Can you tell me about coming to this service? What led up to you coming here? What was the main thing you wanted from this service?
2. What happened when you arrived?
3. What happens now when you come to the service?
4. What contact do you have with staff?
5. Can you tell me why coming here is helpful or not helpful?
6. What qualities do you think are important in the staff that work at health and treatment services? What is their role?
7. Have there ever been reasons that have stopped you from entering treatment or using a health service? What were these?
8. Best and worst health/treatment service experience and why.

9. On the whole, do you think that using health/treatment services has been beneficial for you? In what way? Why/why not?

10. How could health and treatment services change to better respond to methamphetamine use?

11. Can you describe the last time that you took methamphetamine? How did you take it? What other drugs did you take? Who were you with? Where did you get it from? Where were you? What did you do while you were taking it and after?

12. Is this the way that you usually take methamphetamine? If not, under what circumstances you would you normally use it?

13. Do you consider yourself a regular or heavy methamphetamine user? Has using methamphetamine made a big difference to your life?

14. What are some of the harms you have experienced that you think are related to your methamphetamine use?

Thinking about the harms that you have mentioned:

- what kind of support would be helpful to you?
- Is there a health or treatment service that provides that kind of support?
- Which one/s and why?

15. What are the things that you do to use methamphetamine in safer or less harmful way?

16. Do you think that methamphetamine is an addictive drug? Why?

17. Are you addicted to meth? How do you know?

18. Where do you see yourself in 5 years for now – will you still be using?

This interview is about finding out more about methamphetamine users accessing services and how service providers view their role in relation to addressing methamphetamine-related harm. Can you think of anything else along these lines that you think we should know?

Thank you for your time and input

### **Interview Guide: Service providers**

The interview is likely to take about one hour. I'm going to ask you to read the plain language statement to give you a little bit more detail about my study aims, intended outcomes, your participation and your confidentiality.

Do you have any questions about the research or any of the issues identified in the plain language statement? Do you consent to participate in the study?" [if yes, record oral consent].

#### **Quantitative component of the interview:**

Age:

Gender:

Occupation:

Current job title and role

Detailed employment history (positions held, length of time in each position, approximate dates of employment):

#### **Guidelines for the open-ended section of the interviews:**

1. What has brought you to this type of work? What are the rewards/drawbacks?
2. Observations about methamphetamine users accessing the service (eg. Characteristics of users, range of drugs and combinations used, frequency and modes of administration, harms experienced, treatment outcomes).
3. Are methamphetamine users different to other clients? Why, why not?
4. Are there issues specific to methamphetamine use and/or users that make it easier/difficult to treat/address?
5. Is methamphetamine an addictive drug? How do you know?
6. What are the current barriers to accessing your service that methamphetamine users may experience? How has your service attempted to address these barriers?
7. When a methamphetamine user comes to your service seeking treatment, what do you do? Can you give me an example of your last session with a methamphetamine client? Is this a typical session? Why/why not? What usually happens?
8. What do you think is the most effective treatment for methamphetamine use and why?
9. When clients leave here, what should skills and
10. Can you tell me the most important qualities in a service provider at your organisation and why you think they are important?
11. What are your personal guiding philosophies/beliefs/models?
12. What are the models/principles guiding service delivery?
13. Personal impact of such work and ways of debriefing?

This interview is about finding out more about methamphetamine users accessing services and how service providers view their role in relation to addressing methamphetamine-related harm. Can you think of anything else along these lines that you think we should know?

Thank you for your time and input.

## Vignettes

### Case study 1

Amy, a 19 year old female, contacts your service. Amy works in a nightclub behind the bar. She has been smoking crystal recreationally on her days off for the past two years. In the last three months, however, her drug use has increased and she has found herself smoking before she goes to work. When she finishes her shift, Amy usually goes out with her workmates and drinks alcohol and smokes cannabis. She finds that this helps her get to sleep. Amy thinks that her increasing methamphetamine use is causing mood swings and occasional bouts of depression where she can't leave her bedroom.

You see Amy for an initial consultation and she tells you that she loves using crystal, but is worried about the side effects. Also, her boss has had a go at her for having too many sick days and she is worried about losing her job. She wants to go back to just using recreationally – how can you assist her?

### Case study 2

Leo is a 16 year old, polydrug user who uses your service regularly. Leo is unemployed, not enrolled at school and lives in state residential accommodation or at friends' houses. He has intermittent contact with his mother who is unable to care for him or provide financial support. He prefers to use heroin, but also uses methamphetamine (speed or ice/crystal) whenever he can. On average, he uses heroin and meth about 4 times a week. Additionally, Leo drinks around 6 standard drinks daily and smokes at least a gram of cannabis.

Leo comes to see you. He wants help for his heroin use and asks you if you can get him into a detox. He is less concerned about his methamphetamine use, seeing it as a recreational drug and one that he can stop taking if he wants to. fight in the street with an acquaintance over a debt. speed use was to blame for a recent episode where he was picked up by police after a physical

How can you support him?