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How Do Marginalised Young People who are in Contact with Alcohol and Other Drug Services Understand their Alcohol and Other Drug Use and 'Addiction'?

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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 of diploma in any university.

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Abstract

Young people's alcohol and other drug use is frequently associated with negative health and social problems, including addiction (or 'dependence'). In this thesis, I describe my examination of the multiple meanings and trajectories of young people's alcohol and other drug use, with a particular focus on marginalised youth. My aim is to investigate the ways marginalised young people's drug use is constituted in relation to their engagement with services in Australia, along with associated concepts such as addiction. In conducting this analysis, I draw on Tim Rhodes' 'risk environment' framework (Rhodes, 2002, 2009), approaching risk as produced by complex interactions between individuals and environments. I examine the multiple meanings given to alcohol and other drug use by marginalised young people, and explore how social structures and environments (particularly services) influence the construction of meaning, including the production of harm and safety, in relation to drug use and notions of addiction. Through analysis of key policy documents and in-depth interviews conducted with marginalised young people accessing two alcohol and other drug services in Melbourne, Australia, I explore the differences, consistencies and tensions between participant perspectives and service policy and practice. I present this data analysis via the use of detailed case studies, the aim being to generate new empirically grounded insights for service providers, policy makers and researchers into how to reduce inconsistencies between consumer and service understandings of drug use and addiction. I argue that marginalised young people are constituted in alcohol and other drug policy as especially vulnerable, predisposed to risk-taking and unable to make the 'right' choices, irrespective of their individual circumstances. Moreover, I contend that, in suggesting that young people are unable to make the 'right' choices, policy obscures their capacities and encourages the underutilisation of their ability and potential to make effective choices. I also argue that, linked to this, the social contexts and pleasures of alcohol and other drug use for marginalised young people are ignored, with all use conceived as harmful. Participant narratives challenge such simplistic accounts, highlighting how use is often purposeful and intricately connected to social and physical environments. By moving away from focusing on individualised risk-based approaches to alcohol and other drug use and addiction, we can better acknowledge how young people work to develop safer drug-using environments. In concluding, I argue that labelling young people's consumption as intrinsically harmful and risky, as the first step towards addiction, actively creates risk environments in which they struggle to engage services and are denied the ability to negotiate their own engagement.

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Chapter One: Introduction

Young people's alcohol and other drug use is frequently associated with negative health and social problems (AIHW, 2014). Homelessness, mental and physical illness and low socioeconomic circumstances are understood by many treatment services and government organisations to have a linear relationship with alcohol and other drug use, that is, as either caused by or resulting from it. According to the Australian Institute for Health and Welfare (AIHW, 2014), 'in 2010, more than 1 in 5 young people (23%) aged 15–24 reported they had used a non-pharmaceutical illicit drug at some time in their lives' (p. 228). The AIHW also notes that 'young people who engage in risky health behaviours [such as alcohol and other drug use] … place themselves at an increased risk of injury, acquiring a sexually transmissible infection, or developing a long-term illness such as coronary heart disease, liver disease or mental illness' (p. 225). Such cause-and-effect understandings of the relation between young people's alcohol and other drug consumption and harms are widespread. They can be found, for example, in policy and practice responses to the perceived problems marginalised young people encounter in relation to their alcohol and other drug use. However, research indicates that marginalised youth's consumption is far more complex than this.

In this thesis, I examine the multiple meanings and trajectories of marginalised young people's alcohol and other drug use. I explore how policy and service provision influence the construction of meanings around alcohol and other drug use, including notions of addiction, an idea that directly informs many young people's views about alcohol and other drug risk (Fraser, Moore, & Keane, 2014). My key objectives are:

1) to investigate young marginalised alcohol and other drug users' understandings of alcohol and other drug use and 'addiction';
2) to explore the extent to which, and the various ways in which, marginalised young alcohol and other drug users take up, resist and/or accommodate the discourse of 'addiction' that they encounter in their interaction with services; and
3) to provide future direction for service provision to marginalised young alcohol and other drug users.

In doing so, my research is the first to explore the meanings of alcohol and other drug use and 'addiction' among marginalised young Australian alcohol and other drug consumers, and raises questions about the fit between young people's views and priorities and the aims and

practices of services. I take a novel approach to notions of risk and harm associated with alcohol and other drug use, which have received little scholarly attention in relation to marginalised young people. I therefore make four contributions to the field. I provide new research findings on marginalised young people's understandings of alcohol and other drug use and addiction. I examine how policy and services frame alcohol and other drug use and addiction, and consider how marginalised young Australian alcohol and other drug users take up, resist and/or accommodate the discourses of 'addiction' that they encounter in their interaction with services. Lastly, I apply a 'risk environment' framework in an Australian study of young people's understandings of alcohol and other drug use and addiction and their engagement with services – the first time this has been done. My analyses challenge many assumptions that surround marginalised young people who consume alcohol and other drugs and critically examine how service providers' messages and objectives shape notions and attributions of addiction. Together, they generate new insights for service providers, policy makers and researchers, with the aims of helping reduce existing inconsistencies between consumer and service understandings of youth alcohol and other drug use and addiction, and enhancing the relevance and effectiveness of responses.

I begin with a brief overview of young people's alcohol and other drug use, and treatment services in Australia generally and the state of Victoria (where this study was conducted) in particular. Then I canvass the key treatment modalities that operate in Victorian alcohol and other drug treatment, contextualising the empirical aspects of the project. Finally, I introduce the chapters that make up the thesis, explaining my overall approach and arguments.

Before proceeding, it is important to consider terminology. The term 'addiction' is a heavily contested one, often replaced in Australian medical contexts with 'dependence'. In this project, it is deployed as an umbrella term, while also being subjected to critical investigation of the ways it, and associated notions and terms (such as 'dependence'), are constituted and operate in society, culture and politics. In addition, in this project 'marginalisation' is defined by young people's experience of social stigmatisation, early life disadvantage, financial hardship, poor health and social isolation (Cruwys et al., 2013, p. 10). A more detailed explanation is provided in Chapter Three.

Young people and alcohol and other drug use

Much of this thesis concerns young people's understandings of alcohol and other drug use and addiction. The sociological literature on young people's use, the notion of addiction and treatment experiences are explored and critically discussed in Chapter One. Here I begin by outlining what is known about young people's alcohol and other drug consumption and the issues they face.

According to the 2016 National Drug Strategy Household Survey (NDSHS) report (AIHW, 2017a), although tobacco smoking and alcohol consumption declined between 2013 and 2016, 'there were no significant declines among 14–19 year olds in recent illicit drug use' (p. 11). For those aged between 20 and 30 years, 'the only drug to significantly decline between 2013 and 2016 was recent use of meth/amphetamines (from 5.7% to 2.8%)' (ibid). In relation to alcohol use, the NDSHS report mentions 'improvements in young people', who are increasingly abstaining from alcohol or delaying first consumption (from age 14.7 years in 2001 to 16.1 years in 2016) (p. 33). The NDSHS report also states that 'younger people experience harm from alcohol-related accident or injury disproportionately [to their older counterparts] and that alcohol negatively effects their physical and psychosocial development (p. 38, p. 41). In relation to illicit drug use, the NDSHS found that young people in their twenties continue to be the cohort most likely to consume. However, since 2001 the average age of illicit drug users has risen to 20 years (p. 51) and 'people aged 14–29 in 2016 were less likely to have experimented with illicit drugs than people aged 14–29 in 2001' (p. 54). As with alcohol use, for illicit drug use 'people in their 20s were most likely to experience an incident caused by someone under the influence of illicit drugs, with 9.4% reporting they had been verbally abused and 3.6% physically abused' (p. 75). While consumption appears to have changed and decreased over time (especially between 2001 and 2016), young people are consistently identified as being both most likely to engage in illicit drug use and more likely to incur harm from their alcohol and other drug use than other age groups.

The NDSHS report identifies 'young people (aged under 30)' (2017a, p. 11) as a specific population group connected to higher risk and increased vulnerability to alcohol and other drug related harm. Similarly, it highlights particular 'social determinants' which work to produce 'at-risk populations' (p. 14). As I am especially interested in marginalised young people, this official document's presentation of young people as particularly vulnerable, and

social determinants as determining factors in the production of risk, is significant for my research.

Australian and Victorian alcohol and other drug use service engagement

In a recent report on alcohol and other drug treatment, the AIHW (2016a) estimated that 114,912 people received treatment in Australia in 2014 and 2015. In the financial year 2014–15, 843 publicly funded alcohol and other drug agencies provided 170,376 treatment episodes (an average of 1.5 episodes per person) (ibid.). Citing Smith Jorna, Sweeney, and Fuller (2014), the AIHW report (2016a) states that treatment for illicit drug use cost approximately $298 million in 2011. The AIHW (2016a) reports that across Australia, 55% of clients attending services are aged between 20 and 39 years (no further age breakdown is provided at state level in these documents). Across the 2014–15 financial year, 140 publicly funded alcohol and other drug treatment agencies provided 45,855 treatment episodes of care to 25,484 clients (AIHW, 2016b, p. 9) in Victoria. This number of clients contrasts with the Department of Health and Human Services' (DHHS) estimate of 40,000 Victorians[1] accessing treatment services annually (2015a). The explanation for this disparity may lie in reporting of clients numbers versus episodes of care.

As government reviews and research demonstrate, counselling and assessment, support and case management, and withdrawal management remain the most common types of treatment (AIHW, 2017b). I note that although 'assessment' is listed, it is not, in itself, a form of treatment. Other forms of treatment are: 'support and case management only', 'rehabilitation' (both residential and non-residential), 'information and education only', 'pharmacotherapy' and 'other' (p. 12). Determining which form/s of treatment the client will engage with occurs during 'standardised, comprehensive assessments' designed to develop 'initial treatment plans that accompany clients to treatment service' (DHHS, 2015a, p. 3). According to the AIHW, the role of publicly funded alcohol and other drug agencies is to provide 'services to clients seeking treatment and support for alcohol and other drug problems' (2017). There is some ambiguity in this use of the term 'problem', an ambiguity found across the alcohol and other drug sector, along with debate about the nature and attributes of addiction (Fraser et al., 2014). As will become evident below, the participants in this study offered multiple

[1] For a further breakdown of service attendance see Aitken, C., Lloyd, B. & Dietze, P. (2017). Victorian Drug Trends 2016. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trends Series No.166. Sydney, National Drug and Alcohol Research Centre, UNSW, Australia.

perspectives on what they considered to be 'problematic'. In Chapters Five and Six I critically consider to what extent and in what ways policy and service approaches to such problems are accepted, accommodated or challenged by service participants.

The young people who took part in this research form part of the approximately 40,000 Victorians who access treatment services annually (DHHS, 2015b). As in Australia generally, treatment in Victoria follows several streams, including intake, counselling, withdrawal management, rehabilitation and pharmacotherapy. State-funded services are often free of charge, with exceptions for opioid pharmacotherapy treatment, some residential services, and when contributions are requested for pharmaceuticals, complementary therapies and activities (DHHS, 2015c).

Many youth-specific agencies operating in Victoria offer services for individuals under the age of 25 years. These include youth outreach and support, residential withdrawal, home-based withdrawal, residential rehabilitation and supported accommodation (DHHS, 2017b). These services are described by the DHHS as responding to 'alcohol and other drug issues' in this group. The DHHS website describes these youth-specific services as using a family-based approach which integrates services that target 'mental health, education, health, housing, and child protection and family services' (DHHS, 2017b). Given this approach, when young people engage with alcohol and other drug services, there is a strong emphasis on connecting them simultaneously to a range of other services. As the interview data collected for this project will show, young people access these services for a multiplicity of reasons that are not always exclusively motivated by alcohol and other drug use. Indeed, some young people access treatment as it presents opportunities to simultaneously access other services that better suit their needs. However, as I will argue in this thesis, alcohol and other drug-related problems and concepts of addiction remain the focus of many young people's treatment narratives, despite their accounts of additional or alternative requirements for support.

Victorian treatment modalities

The Victorian DHHS (formerly the Department of Health – DoH) plays a key role in shaping what type of treatment is available, and how it is delivered, in the state. In 2013 the DoH published a set of principles 'informed by the literature and in consultation with Victorian alcohol and drug service providers, consumers and their families' to provide 'high level and

aspirational' guidance towards the 'redesign of the alcohol and drug service system' (2013b, p. 2). These comments and principles were reiterated in a 2017 publication:

- 'Substance dependence is a 'complex' but treatable condition that affects brain function and influences behaviour [2]
- Treatment is accessible
- Treatment is person-centred
- Treatment involves people who are significant to the consumer
- Policy and practice is evidence informed
- Treatment involves integrated and holistic care responses
- The treatment system provides for continuity of care
- Treatment includes a variety of biopsychosocial approaches, interventions and modalities oriented towards people's recovery
- The lived experience of alcohol and drug consumers and their families is embedded at all levels of the alcohol and drug treatment system
- The treatment system is responsive to diversity
- Treatment is delivered by a suitably qualified and experienced workforce' (DHHS, 2017a).

In this thesis, I will consider whether mismatches exist between these principles and the services that operate under them. Notably, these principles stipulate a specific approach to how alcohol and other drugs and addiction are conceived, as well as shaping how services respond to clients.

For each episode of care, the DHHS (2017c) strongly advocates a stepped care model to ensure that 'clients can move seamlessly between services in response to higher or lower levels of risk and acuity' (p. 15). The stepped care approach positions people who seek treatment in particular streams based on assessed need. These streams involve initial intake and assessment, following which participants are advised of their capacity and suitability to

[2]The 2013 and 2017 iterations of this document use the term 'substance dependence', but in the draft treatment principles consultation paper (DoH, 2012), the term 'addiction' is used. This demonstrates the changing landscape in which 'addiction' is sometimes employed and at other times avoided, something to which I draw attention throughout this thesis. The terms are frequently used interchangeably, with little regard of the implications and associations that they evoke.

engage in counselling, non-residential withdrawal, residential withdrawal, residential rehabilitation, care and recovery co-ordination, pharmacotherapy, youth-specific alcohol and other drug services or Aboriginal alcohol and other drug services (ibid.). Table 1 presents verbatim the 'purpose' of each type of service, as the DoH defined in *Victorian alcohol and drug principles* (2013). Of particular note is the use of the terms 'addiction' and 'dependence'. Although no definition is provided in this document, 'addiction' is employed when making connections with medical treatment, while 'dependence' is used more loosely to describe a state induced by consumption.

Table 1 – the 'purpose' of services.

Counselling	Counselling supports positive behavioural change in people by providing evidence-based therapeutic individual, group and family counselling interventions (p. 18)
Non-residential withdrawal	Non-residential withdrawal supports people to safely achieve neuroadaptation reversal or stabilisation through an abrupt cessation or gradual reducing regime (p. 20)
Residential withdrawal	Residential withdrawal services support clients to safely withdraw from AOD dependence, in a supervised residential or hospital facility (p. 22)
Therapeutic day rehabilitation	Therapeutic day rehabilitation programs deliver targeted interventions to address psychosocial causes of AOD dependence though evidence-based treatment, with the aim of sustainable recovery (p. 25)
Residential rehabilitation	Residential rehabilitation services provide 24-hour supervision by suitably qualified staff in a residential treatment program of an average of three months duration (p. 26)
Care and recovery coordination	Care and recovery coordination seeks to support integrated treatment and care pathways for the highest-need/risk clients within AOD treatment services, who require a coordinated care response (p. 28)
Pharmacotherapy	Pharmacotherapy is the use of substitution medication, such as methadone or buprenorphine, to assist in the treatment of opioid addiction (p. 30)

Source: Department of Health (2013a)

While youth services are listed in the following section under 'population-specific service systems' (DHHS, 2017a, p. 33), it is important to note that all of these streams are also available within youth services. The key difference is that youth services are available to individuals only up to the age of 25, and, as noted, use a 'family-based approach' (DHHS, 2015a). Along with this general age restriction, individual services sometimes stipulate different age limits on service participation.

In terms of treatment delivery, the Victorian Government describes its approach as 'recovery-orientated' (DHHS, 2017b, p. 12). As noted above, this can involve several streams. Within these streams, services utilise a range of approaches (although, as discussed previously, counselling is the most common form of treatment). Under the umbrella of counselling, services employ techniques such as motivational interviewing, cognitive behavioural therapy or dialectical behavioural therapy (Marel et al., 2016). This is not an exhaustive list; instead,

it provides a sense of the multiplicity of counselling treatment delivery. A diversity of techniques and resources are available similarly across all treatment streams.

The *Victorian Youth AOD Service System* report lists a full range of available youth specific services: outreach; counselling, consultancy and continuing care; community youth residential withdrawal services and home-based withdrawal; day programs[3]; residential rehabilitation and supported accommodation; online and telephone counselling and support; and a range of specialist programs (Bruun, 2015). Many of these programs are not alcohol and other drug focused, but offer a range of welfare supports. The foci of these services reflect the multiplicity of concerns that young people experience.

In the section above I have provided a detailed portrait of the treatment available in Australia, and Victoria in particular. In Australia publicly funded treatment services offer many programs to a diverse range of people. Up to 55% of these clients are under 39 years and counselling remains the most common form of treatment at both national and state levels. Notwithstanding these points, there is little information concerning the detailed breakdown of young people's treatment engagement at national and state levels. In Victoria, youth-specific services offer many programs that target both alcohol and other drug use and other welfare issues. All of these services fall under the Victorian treatment principles. The extent to which services respond to these principles is a focus of this study. The discussion in this section situates my study within the broader alcohol and other drug service system and introduces a sense of the diversity and multiple needs of people who access these services. These needs are explored further in subsequent chapters.

Introduction to the chapters

The chapters in this thesis follow a conventional structure for sociological works. The introduction is followed by a literature review. The theory and method are then laid out, and the data analysis and conclusions follow. In its entirety, this thesis focuses on two key themes: alcohol and other drug use and addiction. Other themes, such as marginalisation, treatment and youth are addressed throughout the thesis (most notably in Chapter Four).

[3] Participation in these programs offer young people opportunities to access primary health care, access and referral to other welfare services, counselling and skill development sessions and other basic necessities including food packs and hygiene services (such as washing machines and showers).

In Chapter Two I present a thorough review of the sociological literature on addiction and young people's contact with alcohol and other drug treatment services. The first section finds the literature oriented to the observation that addiction is not a static illness or affliction, but a progressively developed assemblage of ideas with multiple meanings. The second section focuses on select studies on service user engagement; I mainly explore how service contact helps to shape and formulate service users' experiences and conceptions of the self. Most importantly for my analysis, these works help raise questions for my own analysis of the ways the 'user' and the 'addict' are produced in and through treatment programs. These studies also address the ways people take up and/or resist notions of the addict and the problem drug user. In the second half of this chapter I explore literature that analyses policy. The literature presented considers what goes into making policy, and more importantly, what policy produces. I highlight that ideas taken up in policy documents actively work to produce particular meanings and approaches to the topics they address, such as the concept of addiction.

In Chapter Three I establish my theoretical and methodological orientation. I begin by identifying the key features of qualitative research. After an introduction to the purpose of social research, I consider the applicability of a qualitative methodology for this study. Then, I offer an overview of the shift from traditional approaches to research methods to a poststructuralist methodological approach. As I will explain, traditional approaches are characterised by a search for truth through objective inquiry. However, a poststructuralist account disputes notions of a single reality and essential truth. This account will provide the theoretical underpinning of my investigation. With this theoretical underpinning in place, I introduce the notion of the 'risk environment' (Rhodes, 2002, 2009; Rhodes et al., 2005). The 'risk environment' framework categorises our environments into differing types and levels. Using this context-based theoretical approach, I explore how positive and negative risk is produced and experienced in alcohol and other drug service contact. Next, I present the method used for policy analysis and then the interview method. For the first part, I examined the key national and state policies that govern approaches to alcohol and other drugs. For the second, interviews were conducted with clients from two services (operating at three sites in metropolitan Melbourne). Finally, I detail the data analysis processes and ethical considerations for this research.

Chapter Four marks the beginning of the data analysis, which is divided into three chapters. It explores five key themes: alcohol and other drug use, addiction marginalisation, treatment, and youth, as presented in national and state policy. In the first theme, I analyse the policies shaping and informing service provision in Victoria. In the following two themes, I look at young people's accounts of their experiences in services. Specifically, in Chapter Four I analyse the constitution of alcohol and other drug-related 'problems' and youth in Australian alcohol and other drug policy texts. Here, I build on recent scholarship to explore how 'problems' are actually made and constituted in the policies that aim to address them. This will demonstrate how Australian national and state policy approaches to alcohol and other drug use, addiction, marginalisation, treatment and youth constitute particular realities. Two key Australian alcohol and other drug policy documents are analysed: (1) the *National Drug Strategy 2010–15* (MCDS, 2011) and (2) *Reducing the alcohol and drug toll: Victoria's Plan 2013-17* (State Government of Victoria (SGV), 2012). Drawing on Rhodes' risk environment framework (2002, 2009), I examine the policy 'environment', which I argue works to produce a particular discourse that problematises particular groups of people. The notions of risk, harm and problem that circulate in these policies operationalise a range of assumptions from which particular types of subject are made. In these policies, the marginalised young drug-using subject epitomises the antithesis of the healthy liberal citizen. Social drinking settings are reserved for the well-controlled and rational subject. In contrast, unlike the well-controlled and rational subject, marginalised young drug users are linked to concerns about addiction, crime, trauma, poor health and a loss of volition.

Chapter Five builds on the insights presented in Chapter Four. Here I examine meanings of alcohol and other drug use for marginalised young people engaged with treatment services. How these meanings relate to those constituted in youth alcohol and other drug treatment policy and services will also be considered. As argued throughout this thesis, policy and public discourse on youth alcohol and other drug use is preoccupied by risk. Consequently, policy and services (and drug education, e.g., Farrugia & Fraser, 2015) struggle to accommodate pleasure. This neglects or dismisses the subjective benefits of use, instead attempting to encourage risk aversion. In this chapter, I explore the narratives of 'decline' that participants offered when talking about their alcohol and other drug use trajectories and which reflect policy and service narratives, and consider how they fit with other narrative elements that highlight how alcohol and other drug use can also be purposeful, enjoyable and beneficial.

In Chapter Six, the last of the data analysis chapters, I explore the second key theme: addiction. Having looked at how alcohol and other drug use is understood in policy and service provision, and how this relates to young people's views, I next look at this feared consequence of use. Identifying three sub-themes, I argue that the young people in this study connect addiction to mental and emotional disorder, loss of control, and sickness/withdrawal. I explore how ideas are taken up, accommodated and challenged. It is clear that treatment services are crucial in shaping young people's notions of addiction. It is also apparent that these notions actively shape how young people see themselves. Often this entails responsibilsing individuals for poor choices and individual failings while simultaneously working to set them apart from 'normal' and 'healthy' body ideals. This point is especially pertinent in debates over whether addiction is a temporary or enduring condition. Despite the Victorian DoH's (2013b) assertion that addiction is 'complex but treatable' (p. 4), not all services adopt this approach. As will be detailed in Chapter Two, participants in this study were recruited from two services, one harm reduction oriented and the other recovery or abstinence oriented. In my analysis I found one of the two services conceived addiction as a broadly temporary problem, and the other as a broadly enduring one. Drawing on their interactions with these services, in Chapter Six I investigate how particular subjects are produced through young people's respective treatment engagements.

Finally, in Chapter Seven I present my conclusions for this research. I reflect on the two major themes I investigated: the meanings given to alcohol and other drug use and to addiction, and consideration of these meanings in light of young people's own stated priorities and concerns. I argue that youth treatment engagement is an active process in which particular subjects are produced as a response to service approaches and perspectives. Further, these approaches and perspectives can be said to produce risk and harm within these contexts: they are part and parcel of marginalised young people's risk environments. I suggest a need instead for a more nuanced understanding of alcohol and other drug harms, more careful attention to the different environments in which alcohol and other drug use occurs and to young people's own concerns and priorities, and to consider how policies, services and individual experiences together constitute young people's consumption.

Chapter Two: Literature Review

In my review of the literature I explored the existing scholarship on key issues relating to young people and their understandings of alcohol and other drug use and addiction. The first section of this chapter, 'The sociology of addiction', traces the development of sociological thought on the construction of addiction across Western societies. As I will argue, few publications consider marginalised young people's perspectives in their analysis of addiction and alcohol and other drug consumption. This is problematic and constitutes a significant gap in knowledge. In the second section I explore the literature on young people's alcohol and other drug use. Divided into two subsections, it presents literature on 'mainstream' and 'marginalised' young people. I also consider this distinction, noting that these categories do not sit opposite each other, but work to shape approaches to use. The third section of this chapter focuses on Australian literature on alcohol and other drug treatment experiences. This review highlights dominant approaches adopted in the Australian treatment system, while simultaneously identifying a silence on young people's experiences. In the fourth section, I turn to literature that has analysed policy, its purpose and its products. As I will argue, policy is both a type of environment (explained in Chapter Three), and an active process in which particular ideas and environments are made. The literature demonstrates that policy is a collection of ideas formed by multiple factors, including public values, budgetary imperatives, and ideology. In much of the literature reviewed in the policy section, scholars repeatedly call for policy makers to acknowledge the complexity of alcohol and other drug-using experiences. Similarly, they call for recognition that alcohol and other drug policies constitute and produce the problems they seek to address. Collectively, the literature presented in this chapter provides the foundations on which subsequent analysis rests on for this thesis. The environments in which policies occur shape and are shaped by ideas of alcohol and other drug use and addiction. One of my principal research aims is to explore how marginalised young Australians experience alcohol and other drug treatment, and how the environments in which they engage contribute to their experiences.

The sociology of addiction

Since the concept of addiction began being taken up in earnest in the late 19th century (Raikhel & Garriott, 2013), sociologists have sought to explain the various ways it is understood and to map the role of culture and context in shaping its meaning. In his analysis of responses to alcohol problems, Robin Room (1986) points towards the development of institutions 'specifically for the cure of the inebriated' that arose 'in English-speaking

societies in the latter half of the nineteenth century [at the behest of] doctors, and to some extent other interested groups such as temperance workers and clergy' (p. 388). This approach problematised particular consumption practices and introduced notions of 'curing' and 'healing'. In this section I will identify how addiction has been understood sociologically and evolved over time. Key figures in the field are Stanton Peele, Robin Room, Norman Zinberg and Harry Levine. This review will cover their work briefly and then explore more recent contributions.

In their 1975 book *Love and Addiction*, Peele and Brodsky confront stereotypes of 'physical addiction' and 'drug addiction'. In thinking about love, the authors trace the links between love and addiction, and addiction and 'drugs'. In doing so, they argue that we need to look beyond chemical effects or physical symptoms that we associate with addiction, and explore the range of factors that govern human responses to drugs, including personality, cultural background, and assumptions about drugs and their pharmacology. Social and cultural factors were also the focus of Room's (1976) analysis of drinking practices in the United States. Room examines religious stipulations for alcohol consumption to demonstrate how meaning is created through social practices, and contends that drinking customs are a 'crucial cultural factor in the etiology of alcoholism' (p. 1049). He identified how labels of addiction are more often attributed to those who deviate from cultural norms than those who comply with them. Norman Zinberg further developed this approach when he published the enormously influential book *Drug, Set and Setting* (1984), which identifies three main elements that shape drug experiences:

1. *drug*: the pharmacology of the substance/drug;
2. *set*: the personality structure and the attitudes (or mindset) of the individual; and
3. *setting*: the physical and social setting of consumption.

Contrary to popular perceptions that drugs alone cause consistent effects, Zinberg (1984) argues that setting is the most important factor shaping drug use experiences, and notes that despite this, it had received little scholarly attention. Through his examination of the role of social rituals in alcohol and other drug use, Zinberg's work encouraged the sociological examination of cultural and social factors shaping drug consumption and addiction.

Subsequent to Room's exploration of alcoholism in the United States, Harry Levine (1985) conducted a historical analysis of the evolution of addiction through the temperance movement. During the colonial era, he argues, to be 'addicted' meant 'habituated' and its connections were to the experience of intoxication, not to the substance consumed (p. 45). However, to be 'habituated' was not in itself problematic, as frequent (yet not necessarily excessive) consumption of alcohol was a normalised practice. However, the advent of Prohibition initiated a radical shift in addiction discourse. As Levine argues, 'drunkards' were often perceived as criminals (p. 45). According to Levine, it was not until the 1930s and 1940s that the concept of addiction (or habituation) was 'rediscovered' and gained credibility within academic circles (p. 51). At this time, academics argued that addiction was an internal experience of desire and associated with the loss of individual will. Levine concludes that 'addiction' evolved in academic inquiry from a surface notion of 'habitual drunkenness' to focus on human will and desire (p. 52). He argues that addiction was increasingly seen as a disease of the will in response to society's increased valuing of self-control and self-determination through the rise of the middle-class. Room (1986) also examines this change in societal perceptions of alcoholism and addiction, tracking the rise of 'inebriate institutions'. In his view, measuring success or failure in these different institutions reflects the changing perceptions of alcohol problems and shifts in societal tolerance of alcoholism. Also taking a social approach, Peele (1990) responded to Levine's (1985) discussion of the rise of addiction. In this article, he questions the assumptions that enable addiction to be perceived as a disease (1990, p. 206), arguing that the concept of addiction cannot be explained by medical or biological approaches and, instead, is 'better understood as a cultural phenomenon that fulfills functional and symbolic needs' in society (p. 206). These early works represent a significant advance in the sociology of addiction as they reject traditional medical discourses and emphasise influences of cultural and structural factors. Overall, Peele, Room, Zinberg and Levine's contributions identified the limitations of biological approaches to addiction, raised questions about its coherence as a concept, and opened up to scrutiny for the first time the role 'addiction' plays in a society's understanding of itself.

In 1993, poststructuralist thinker Eve Sedgwick published a highly influential book that refined and sharpened the questions others had asked about the meaning of addiction. Entitled 'Epidemics of the will', it gave new direction to theoretical approaches of addiction. Arguing that an 'epidemic of addiction attribution' (1993, p. 133) was underway, Sedgwick related the rise of addiction concepts to the Enlightenment's instantiation of reason and free will as key

values. In this, Sedgwick examined the construction of alcoholism through 12-step programs that command participants to 'own' their addiction and accept that they will never be 'free' of their condition. As Sedgwick argues, the patient's 'lack of freedom' hinges on the ideal of autonomous freedom common to liberal societies, without which addiction or enslavement would mean nothing. In her view, the concept of addiction acts to support the idea that Western liberal subjects do indeed have access to free will. This work has since become an important platform for poststructuralists as they explore current attributions of addiction.

Although not described as such at the time, Peele and Levine's work has since been characterised as social constructionist; Room's work has also been described in this way. In 2001, he applied this approach to his analysis of drinking behaviour. Similar to his 1976 work in which he explored how religious principles guide drinking practices, Room (2001) notes that drinking behaviour is culturally constructed, and emphasises that 'while drunkenness everywhere makes people clumsy, its effects in terms of bad behaviour… differs greatly from society to society' (p. 189). He makes the point that the effects of alcohol vary depending on expectations that differ across societies. From this point of view, it becomes possible to acknowledge that alcohol and other drugs do not independently produce harm and addiction; instead, these effects are socially and culturally shaped. Similar to Room's approach, in 2001 Helen Keane analysed the concept of addiction and how it is mobilised in culture. Her focus however, was the 'true stories' of three 'recovering addicts'. In this article she argues that autobiographical narratives of addiction are shaped by 'normative investments of addiction discourse' (pp. 570-571). Developing Room's ideas, she contends that 'the addicted body appears not as a straightforward outcome of drug and alcohol use, but as a site where psychic, social, political and cultural forces are materialised' (p. 592).

Building on Sedgwick's (1993) poststructuralist arguments, Janet Brodie and Marc Redfield (2002) consider how 'addiction and culture become concepts that float and overlap, refer to and interfere with each other' (p. 1). Their edited collection of essays, *High Anxieties: Cultural Studies in Addiction,* includes two chapters of particular relevance here: Margolis' piece, which examines how desire has come to be conceived as a defining 'symptom' of addiction, and Melley's piece, which questions current attributions of addiction and the notion of free will as advocated in Enlightenment thought. According to Melley, although it is the individual who experiences addiction, this experience is shaped by a multitude of cultural factors and expectations. This argument correlates with Keane's (2002) examination

of the multiple discourses that have shaped perceptions of addiction to nicotine and the ways ideals of the healthy body, combined with the legal status of tobacco, have made smokers differently from other drug consumers: 'victims' rather than 'criminals'. Overall, this collection demonstrates that the singular term 'addiction' has multiple meanings and constructions, and that far from being a fundamentally stable problem, addiction is constantly produced and reproduced as a cultural agent. Also published in 2002, Darin Weinberg's article on addiction critiqued three key theoretical approaches to addiction (neurological, learning theory and symbolic interactionism) to demonstrate, like Brodie and Redfield (2002), that addiction is cultural, and not limited to individual cognitive processes. He also identifies persistent assumptions about how addiction is understood in Western societies, such as the criminal versus victim dichotomy mentioned above.

The cultural origins of addiction is a key focus for other scholars too. Keane's influential 2002 book, *What's Wrong with Addiction*, systematically deconstructs assumptions about addiction, making use of the sociological literature to expose the empty core of addiction concepts. Keane also challenged ideas about addiction and free will, going so far as to question the assumptions that addiction is 'bad', that addicts are slaves to the substances they consume, and that dependence is in itself a catastrophe. Keane's deconstructionist approach to addiction is also found in the work of the leading poststructuralist philosopher Jacques Derrida (2003). In a 2003 interview he explored popular assumptions about drug use, noting that 'drugs' is just a 'buzz word', a concept 'instituted on the basis of moral or political evaluations' (2003, p. 20). Like Keane (2002), Derrida contends that the category of drugs is not a scientific one, instead it is merely a moral and political category. Thus, 'drugs' and other concepts relating to their use do not exist as such in nature, but are merely a representation of current preoccupations and concerns.

The thorough critique of the 'truth' of addiction achieved by these works also prompted a related interest in subjective stories of addiction. Room argues that addiction is a product of cultural norms concerning consumption, while consumption practices are 'an arena for a wide variety of symbolic behaviours' (2003, p. 1). This approach was adopted by Severns (2004) who, working in the United States, examined how the nation's history has shaped 'our current version of the 'truth' about drugs, alcohol, the drug addict and the alcoholic' (p. 149). Reflective of Keane's (2001) earlier claims, Severns argues that the truth is developed by social experiences and shared through narratives. In short, individual consumption practices

help individuals develop an understanding of their own experiences as addiction, which they then translate into what they know to be true. The problem is to some extent an arbitrary category that mainly works to inspire stigma.

As much of the literature in this section has detailed so far, the concept of addiction was not born out of a scientific discovery. As Reinarman (2005) notes, addiction-as-disease is embraced by 'virtually everyone in the treatment industry' (p. 307), yet it 'did not emerge from the natural accumulation of scientific discoveries; its ubiquity is a different species of social accomplishment' (p. 308). In his article, Reinarman sketches out how addiction-as-disease is socially constructed and has become a framework to understand a multiplicity of behaviours. It inspires a particular gaze in which drug use teeters into the realm of public health over criminal law. Related to this argument, Preyde and Adams (2008) examine 'expert' attempts to create labels and categories. They argue that society seeks to identify symptoms that are indicative of a greater problem, such as compulsive behaviour. Likewise, Fraser & valentine discuss 'problematic' drug use in their 2008 book *Substance and substitution: methadone subjects in liberal societies*. This book is a major Australian work that explores alcohol and other drug use, addiction and experiences of treatment. It too includes an examination of how notions of problematic drug use are shaped by power and privilege. The authors argue that popular narratives of the destitute 'junkie' are created by policy and politics, and fuelled by economic imperatives. The findings of their analysis of Australian treatment experiences are explored later in this literature review.

Since 2010 there has been a growth in scholarship on the sociology of addiction that builds on the constructionist works of Room and the poststructuralist threads found in the work of Sedwick, Derrida and Keane. Fraser and Moore's (2011) edited collection, *The drug effect: health, crime and society*, relies on the idea that knowledge and even 'reality' itself are socially produced. In their introduction, Fraser and Moore draw on Sedgwick (1993) and Brodie and Redfield (2002) to contend that 'addiction and modern society *have made each other, and they continue to rely on each other for meaning'* [emphasis in the original] (p. 7). They argue that the meaning of addiction is developed by continual mutually constitutive processes of social, cultural and policing practices, medical procedures and media texts. They reject the assumption that drugs are 'concrete entities possessed of intrinsic characteristics and producing predictable results' (p. 1) and focus on how drugs and addiction are socially produced in ways that have specific negative political effects. Illustrating this point,

Manderson (2011), in the same volume, examines how 'the debate between "zero tolerance" and "harm minimisation" continues to frame drug policy debates the world over' (p. 234). In his chapter, he studies what he calls the subconcious drives behind drug laws and, like Sedgwick (1993), contends that 'the drug user… is held up as a – perhaps the – threat to the modern ideology of autonomy and freedom: held up, set apart and scapegoated' (Manderson, 2011, p. 230). The key argument in this chapter is that drug laws (and so-called 'zero tolerance' policies) are not designed to eliminate drugs, but instead they invite stigma and criticism. Overall, this volume provides a clear argument in support of the examination of 'addiction' and 'drugs' as unstable and malleable socially produced categories.

Related ideas were explored in the same year by Summerson Carr (2011). Like Keane (2001) and Room (2003) before her, Carr uses 'stories' in her research. She explores how service users, labelled as addicts, must present 'scripts' that speak to predefined 'realities' in order to approximate the responses their health service providers expect. She notes that these constructed realities also shape broader perceptions of the 'addict' and addiction experiences. This view also informs Weinberg's (2011) work. Closely linked to his 2002 study, Weinberg (2011) identifies three key areas of contemporary scholarship in the sociology of addiction: the functionalist perspective, rational choice theory and social constructionism. He argues that of these approaches, social constructionism has been particularly influential in addiction studies. From this, he contends that 'addiction is not only influenced by social factors but is also fundamentally a culture-bound phenomenon – that it is unintelligible outside the nexus of cultural practices and beliefs within which it is found' (p. 304).

All these scholars – Keane (2002), Preyde & Adams (2008), Fraser & valentine (2008), Moore & Fraser (2013), Carr (2011) and Weinberg (2011) – challenge assumptions that deem illicit drug use to be problematic and addiction as a self-evident problem. Instead, they argue that addiction is made through multiple factors (including laws, cultures and policies that govern), and is not simply a result of alcohol and other drug consumption.

In keeping with Fraser and Moore's (2011) poststructualist arguments, Raikhel and Garriott (2013) propose that the multiple realities of addiction can be understood through the consumer's 'trajectory of experience' (p. 8). Raikhel and Garriott use the story of 'Pavel' (a Ukrainian opium user who travelled to Paris) to demonstrate how time, culture and individual experiences affected his own perception of 'addiction' (p. 2). In 2013, Todd Meyers too

examined user perceptions. He considers the implications that drug treatment programs have for adolescents who encounter services, arguing that therapy experiences for addiction cannot be explained as a single story. Not only do treatment experiences vary, but, depending on therapies, so do constructs of 'curing' and 'healing'. Here, the healthy body is a construct, defined by particular goals and objectives that are frequently assigned based on statistical norms. Raikhel and Garriott's findings support later claims made by Fraser, Moore and Keane in their book *Habits: Remaking Addiction* (2014). Nearly 30 years after Levine's study of habitual drunkenness, Fraser et al. (2014) provided a critical analysis of the developments of the field and using a wide range of empirical data, examined current attributions of addiction (see also Sedgwick, 1993). Building on an argument offered by science and technology studies scholar Steve Woolgar (2011), the authors reject the articulation of addiction as a grammatical noun (state of being). In their view addiction is a grammatical verb, a politically specific process of ascription (as explained by Woolgar's notion of 'gerunding' (cited in Fraser et al., 2014)). Based on the constructionist insights offered in earlier scholarship, but refined via contemporary notions of reality as proposed by John Law (2011) in his discussion of 'collateral realities' (p. 156), the authors argue for addiction as 'an unstable assemblage made in practice', one that creates many other key 'collateral realities' for Western culture 'along the way' (Fraser et al., 2014, p. 235).

These works have been followed by a range of other critical studies that cover, for instance, addiction experiences in Australia (Pienaar et al., 2015), the role of social media such as Twitter in promulgating addiction concepts (Dwyer & Fraser, 2016), and the ways in which policy makers and service providers around the world must struggle with the instability of addiction concepts in their work (Fraser, 2015). A particularly notable piece for this review is Dwyer and Fraser's (2016) recent analysis in which they consider the ways in which the standardised screening and diagnostic tools used to diagnose addiction and assign resources to those affected work to produce the very phenomonon that they seek to measure. They identify five main ways that the tools aids this process, through reduction, expression, quantification, normalisation and populationisation (p. 14). These findings provoke an awareness of the ways in which 'tools', which do not heed the effects of language and erase differences across and within categories, work to produce rates of addiction that favour some social groups and alienate others (ibid.).

A final piece of literature considered in this review draws on 20 personal accounts of alcohol and other drug 'addiction' collected in Australia. Like Reinarman (2015), Pienaar et al. (2016) point to the highly influential disease model and its limitations. The authors argue that, under a disease model, addiction is often conceived in terms of dichotomies: volition/compulsion, rationality/irrationality. However, as their interview accounts illuminate, addiction is a co-constituted phenomenon that instead of founding experience, is made 'in its encounters with [many factors, such as] social isolation, marginalisation, homelessness and institutional neglect but also in the pleasures of partying, socialising, responsible work and a full life' (p. 14).

As this selection of recent literature suggests, understandings of addiction are continually evolving and being moulded by many contributing forces and factors. Notions of control, rationality and compulsion have been comprehensivly explored across the sociological literature. What is now also being introduced is critical scholarship that explores how different mediums, such as the internet, policy and practice, also work to constitute the addiction problem in particular ways. At the same time, personal accounts continue to demonstrate that addiction experiences are multiple and rarely conform to narrow taken-for-granted accounts.

Based on this review of the literature, it is possible to argue that the sociology of addiction performs two related analytical moves: it analyses 'addiction' as a product of, and shaped by culture and setting (e.g., Brodie & Redfield, 2002; Derrida, 2003; Dwyer & Fraser, 2016; Fraser, 2015; Fraser & Moore, 2011; Fraser, Moore & Keane, 2014; Keane, 2001; Manderson, 2011; Pienaar et al., 2015; Pienaar et al., 2016; Raikhel & Garriott, 2013; Reinarman, 2005; Room, 1976, 1986, 2001, 2003; Zinberg, 1984) and it challenges the popular misconception that 'addiction' resides in and is defined within the individual (e.g., Fraser & valentine, 2008; Levine 1985; Melley, 2002; Peele & Brodsky, 1975; Preyde & Adams, 2008; Sedgwick, 1993; Severns, 2004; Summerson Carr, 2011; Weinberg, 2002, 2011). Rejecting addiction as an internal process arises from poststructuralist arguments that recognise the multiple discourses and cultural pressures that shape social concepts, the subject and experience. This literature sees addiction as both socially constituted and materially real. If we can see addiction as socially constructed over time, not just a biological fact, we can study this construction.

These insights are of key importance for my project. When young people encounter, or take up, an idea of addiction in coming into contact with services, this reshapes their experience of alcohol and other drug use – it does not merely address it. The contact forms an important part of the construction process. This leaves open the question of whether this process is optimal for young people, whether and to what extent it relates to other aspects of experience for them, and what kinds of construction might work best to help marginalised young people account for their circumstances, access the resources they need, and identify and fulfil their aspirations.

The sociology of young people's alcohol and other drug use

Having explored the literature on large questions about the nature and origins of addiction concepts, I now turn to literature on young people's alcohol and other drug use, focusing my analysis on sociological works published in the last decade. As I will illustrate in the first subsection, research on 'recreational use' and 'recreational users' shows that some forms of alcohol and other drug use are accepted within mainstream leisure culture, and are part of everyday life for mainstream youth. However, this project also examines marginalised young people's alcohol and other drug use that is deemed 'problematic' and considers their perceptions of addiction as a result of their contact with alcohol and other drug services. Difficulties with terminology arise here in relation to 'mainstream' and 'marginalised' users. Defining these terms, and the degree in which someone may be considered to fall within either category is hindered by the complexities of each term. There is no static basis for these terms, instead, to be 'mainstream' or 'marginalised' is an active process and any definitional criteria must be understood to be only temporarily applicable, constantly requiring revisiting depending on an individual's circumstances. Importantly, while alcohol and other drug use is now understood as both a mainstream activity *and* an aspect of marginalisation, different judgements are often made about the meaning of this use depending on the social status of the young person in question. The concept of marginalisation and a definition of it (as used in this project) is offered below and revisited throughout this thesis.

Exploring the literature on normalised use illuminates how particular attitudes and judgements are attributed to some users and not others. This allows the identification and problematisation of assumptions about normality that might be otherwise invisible in this research. As noted above, this section of the literature review is divided into two parts. The first focuses on mainstream alcohol and other drug use and users, and the second examines

marginalised alcohol and other drug use and users. Given the limited literature that focuses particularly on young Australians who use alcohol and other drugs, and the often-blurred lines between 'mainstream and marginalised use' and 'mainstream and marginalised users', I have included literature that addresses both. The literature, presented chronologically, moves between focusing on types of use, and types of users. In doing so, I aim to highlight the fluidity of these categories. This research project defines marginalised users as those young people experiencing social stigmatisation, early life disadvantage, financial hardship, poor health and social isolation (Cruwys et al., 2013). In establishing this definition, however, it is important to note that both mainstream and marginalised young people can use alcohol and other drugs recreationally, just as members from both groups may use substances problematically. 'Mainstream' and 'marginalised' carry a diversity of definitions and intent, and overlap at times; in short, they should not be treated as antonyms.

The sociology of mainstream alcohol and other drug use among young people

In order to examine how alcohol and other drug use among marginalised youth is understood, it is also important to consider how 'normal' alcohol and other drug use is understood, and how different members of society engage in recreational use. In 1998 Parker, Aldridge and Measham published *Illegal leisure*, an important work in this field. The book examined mainstream young people's alcohol and other drug use in Britain, inaugurating a great deal of research on recreational and leisure-based consumption and how it is linked to social and cultural forces. Drawing on the conclusions made in *Illegal leisure*, Cameron Duff explored recreational and leisure-based alcohol and other drug use (2005) when he applied the book's 'normalisation thesis' (a theory that argues that recreational illicit drug use is becoming normal and acceptable) to a mixed method research project conducted in Melbourne, Australia. Duff argues that the prevalence of consumption, matched with a sanguine attitude toward consumption, demonstrates changing attitudes among users and non-users alike about young people's illicit drug consumption and that drug policy and prevention strategies need to reflect these changes. Exploring current changes in recreational alcohol and other drug use practices and building upon their already extensive field research, Measham and Brain (2005) conducted semi-structured interviews and observational fieldwork to examine the 'evidence for a "new" culture of intoxication' in Britain (p. 262). Although Duff (2005) recognises new trends, Measham and Brain (2005) argue that the new culture of intoxication entails four changes in consumption practices which together indicate a significant leap rather than a progression from previous movements. Measham and Brain recognise that although '"binge"

drinking is an emotive, disputed and unhelpful dichotomous term' (p. 268), changes in consumption practices and the popularity of drinking for the purpose of getting drunk have occurred. Measham and Brain link these drinking practices and the 'determined drunkenness' they identified to the creation of a new identity whereby young people 'purchase' their identities through the market and their consumption of alcohol and other drugs, and in doing so practice self-policing (pp. 276-277). Another British study by Sanders (2006) using data collected through observation and interviews, demonstrates that ecstasy use is an integral part of 'club culture'. Sanders (2006) also identifies multiple experiences and pleasure-seeking aspects of consumption. Lankenau (2006) agrees with Sanders, arguing that 'good' and 'bad' drug experiences are subjective and unique. Lankenau's examination of ketamine users' narratives demonstrated that drug experiences are characterised by different understandings of the drug's potential effects.

Stimulated by the media attention on 'binge' drinking, Measham's (2008) selective narrative review of quantitative and qualitative data provides insight into the positive reasons that young people give for drinking and getting drunk. Again Measham argues that, similar to illicit drug use (e.g., Duff, 2005; Green, 2012), drunkenness is becoming normalised in Britain (e.g., Griffin, Bengry-Howell, Hackley, Mistral, & Szmigin, 2009; Measham, 2008). Positive motivations for consumption were also identified by Olsen in 2009. In this study, ecstasy is described as a substance 'that could enhance a social event through its ability to provide enhanced energy' (p. 181). Participants deemed this recreational use acceptable and not indicative of an addiction, which they related to lack of self-control and use outside leisure/pleasure time (186). Numerous authors have examined self-control and harm minimisation techniques, and qualitative research on user perceptions frequently reports on ways that people ensure their safety and limit their alcohol and other drug use. For instance, Green and Moore (2009) conducted ethnographic fieldwork on the social dimensions of young adult use of dexamphetamine in nightclubs and private parties. Green and Moore found that this was frequently understood to differ from illicit drug use, and provides a lower-risk alternative to it. These findings support Lankenau's earlier arguments and demonstrate how users make informed choices about their consumption based upon personal expectations of the substances they consume. The concept of 'self-control' was further explored by Lindsay (2009), who used it as a central theme in her analysis of the 'staging [of] intoxication' (p. 371) and how young people's drinking stories are shaped by their positive and negative experiences of consumption. Lindsay argues that young people exercise self-

control while drinking to balance pleasure-seeking with responsible practices. Similar to this, Fry (2010) used a narrative theory approach to examine young people's 'sensible drinking' (p. 1279) practices. Elaborating on Measham's (2005) arguments about drinking identities, Fry (2010) claims that this study calls for 'greater understanding [of] identity, resistance consumption, and consumer culture to shed light on how meaningful subject positions of 'sensible drinking identities' are created against dominant norms' (p. 1292).

Siokou, Moore and Lee (2010) examined subcultural alienation in Melbourne's 'night time economy' and argue that a lack of social cohesion in venues can negatively affect the pursuit of pleasure. Leisure spaces were further examined in Green's PhD thesis (2012), and like Duff (2005), she used the normalisation thesis to help examine young people who 'negotiated the complex, overlapping and contradictory values and boundaries of acceptable drug use' (Green, 2012, p. 244). In the same year, Pennay (2012) published an article based on 14 months of ethnographic research into mainstream young 'party drug[4]' users' control and monitoring of themselves while intoxicated. Pennay identifies ideals of the 'healthy body' in this group, arguing they contradict popular beliefs surrounding drug use, carnal pleasures and the grotesque body. Overall, this research examines the shaping of the 'truth' about drug use by recreational drug users and how these ideas conflict with legal, medical, public health and media discourses.

British and Australian government initiatives targeting youth 'binge' drinking (see research on these by Lindsay, 2009; Measham, 2008; Measham & Brain, 2005) and media scrutiny of alcohol consumption (e.g., Brown & Gregg, 2012; Lindsay, 2009; Measham, 2008; Townshend, 2013) have also attracted scholarly attention. In response to these initiatives, Brown and Gregg (2012) identify a 'pedagogy of regret' in their article on British government initiatives to curb harmful drinking practices (p. 357). Drawing on earlier work by Griffin et al. (2009), who examines 'passing out' stories, Brown and Gregg (2012) argue that 'a 'bad' story becomes a 'good' anecdote' (p. 361) which can be shared during drinking experiences and through social media. Importantly, the authors examine gender stereotyping and the attribution of blame for negative outcomes through women's pursuit of drinking

[4] This category refers to a group of illicit drugs that are commonly used within party and nightclub settings. There are different interpretations regarding what illicit drugs belong to this category, however the general consensus is that 'party drugs' broadly include: meth/amphetamine, cocaine, MDMA, GHB, ketamine, LSD and cannabis.

pleasure. The authors note that television commercials convey messages that 'women render themselves sexually available by drinking' (p. 359) and court 'inevitable regret and remorse' (p. 357) if they do drink heavily. Interestingly, the young women show little sign of adopting the campaigns' shaming messages. Alcohol 'stories' were also examined in Townshend's (2013) qualitative study. As in many studies before them (e.g., Foster & Spencer, 2013; Leavy, Wood, Phillips, & Rosenbery, 2010; Lindsay, 2009) the young participants resisted the idea that their own substance use was problematic or harmful. This research shows how social, physical and regulatory aspects shape and define alcohol consumption among youth (Townshend, 2013).

Hernandez, Leontini, and Harley's contemporaneous (2013) qualitative study of young people's alcohol consumption examines two themes: young people's alcohol consumption concerns and their attitudes to state initiated harm-minimisation campaigns. Hernandez et al. argue that the avoidance of 'pleasure messages' is a weakness of state-initiated harm-minimisation campaigns. Farrugia (2014), who identifies a gap between young people's current drug use and drug education messages, makes another criticism of state campaigns against youth alcohol and other drug use. He contends that drug education fails to address the experiences of consumers. Despite research (e.g., Green, 2012; Lindsay, 2009; Pennay, 2012) that advocates consumer control, Australian drug education appears to be dominated by messages that treat youth as uncontrolled consumers. As Farrugia (2014) argues, these messages erase the possibility of pleasurable experiences and safe drug use practices.

The literature on the sociology of mainstream alcohol and other drug use among young people highlights that some practices are both accepted and integrated in particular cultural settings. As much of this literature suggests, mainstream alcohol and other drug use is governed by particular norms and practices, thus highlighting the importance of 'set' and 'setting' (Zinberg, 1984) when analysing consumption practices. Often, people who deviate from these norms find themselves and their using practices marginalised. In the section below I explore the literature which highlights this contrast.

The sociology of marginalised alcohol and other drug use among young people

In 2008, valentine and Fraser argued that 'while the pleasures of drug use are sometimes acknowledged, they are normally limited to those who are socially privileged. The drug use of those who are impoverished and marginalised is linked instead to crime, social misery and

addiction' (p. 410). Thus, alcohol and other drug use by marginalised young people is commonly conceived in terms of harms and risks and as reflective of 'deeper dynamics of social marginalisation or alienation' (Bourgois, 2003, p. 2). This claim is supported by research that connects drug use to crime (e.g., Aitken, Moore, Higgs, Kelsall, & Kerger, 2002; Carnwarth & Smith, 2002; Dixon & Coffin, 1999; Midford, Acres, Lenton, Loxley, & Boots, 2002), mental health (e.g., Hadland et al., 2010; Topp, 2011; Yap, Reavley, & Jorm, 2012) and homelessness (e.g., Keys, Mallet, & Rosenthal, 2006; Mallett, Rosenthal, & Keys, 2005; Rosenthal, Mallett, Milburn, & Rotheram-Borus, 2008). But how are these relationships made? From a sociological point of view, there is scant Australian research that uses a social constructionist approach to understand marginalised young people's consumption practices and the meanings attached to them, in contrast to the amount of literature that considers mainstream users. There is also scarce research on how marginalised young people are characterised by alcohol and other drug services and how their use is framed. Due to this shortage, this section includes Australian and relevant international studies. Numerous scholars (e.g., Foster & Spencer, 2013; Fraser et al., 2014; Keys & Rosenthal, 2006; MacLean, 2007, 2008; MacLean, Bruun, & Mallett, 2013; Mallett et al., 2005; Mayock, 2005; Van der Poel & Van de Mheen, 2006) have made valuable contributions to this area by focusing on marginalised young people's attitudes towards and understandings of alcohol and other drug use. These works are discussed below.

Mayock used risk theory to analyse data collected in a longitudinal ethnographic study conducted in a Dublin inner-city community. Participants (aged 15–19 years) presented a variety of drug use narratives and journeys including non-use, recreational and problematic use. Based on the findings, Mayock (2005) argues that the costs and benefits associated with alcohol and other drug consumption are not static for young people, nor do they reflect a unanimous or majority opinion; they are instead varied based upon 'social contexts of belief and behaviour' (p. 351). Furthermore, Mayock's analysis demonstrates that emphasising 'choices' in alcohol and other drug use evokes notions of free will (Sedgwick, 1993) and facilitates moral arguments and inaccurate binaries between recreational and compulsive use. These arguments also extend to definitions of problematic use. Mayock (2005) identifies that 'drug journeys […] are intimately associated with risk', and she proposes that young people are drawn to risk taking and 'scripting risk' as a central means of gaining experiences (p. 362). 'Scripting risk' is used to describe how young people understand and change their consumption practices based on their evolving understanding of risk. In relation to

'problematic' use, Mallett et al. (2005) conducted brief interviews with homeless young people about their 'pathways into homelessness' (p. 185). Mallett et al. explored 'leaving-home' stories (p. 187) and identifies the significant role of family conflict in young people's drug use and its connections to homelessness. They concluded that although drug use has been and can be linked to homelessness, sweeping generalisations about causation are counterproductive for understanding the complexities of young people's drug use. A year after Mallett et al. published their examination of drug use and pathways to homelessness, Keys and Rosenthal (2006) published their findings from a five-year longitudinal study of 40 homeless young people's accounts of 'self-reported problematic drug use' (p. 68). Based on these accounts, Keys and Rosenthal note that 'young people's drug taking does not follow a single trajectory' (p. 70) (see also Raikhel & Garriott, 2013) and they identify consequent difficulties this has for establishing trends in alcohol and other drug use. Van der Poel and Van de Mheen (2006) argued that 'crack use, sources of income and homelessness are intertwined' (p. 52). Their interviews with 30 current and former crack users in Rotterdam suggested that while participants were in a marginal position prior to using, their use accelerated the process of marginalisation. 'Marginalisation' in this article is divided into three dimensions: 'social relations; economic situation; and health situation' (p. 46),from which the authors conclude that the factor contributing most strongly to marginalisation is the social dimension that links into drug use networks.

The following year, MacLean (2007) focused on marginalised Australian young people's 'chroming' practices. Noting strong correlations between inhalant use and social and economic disadvantage, MacLean's aim was to explore 'how some marginalised young people in Melbourne employ hallucinogenic drug use to enact selfhood through four meaning-making practices that have been observed in electronic games and other contemporary global youth culture products' (p. 404). Participant responses included detailed accounts of experiences when chroming, which demonstrated how young people 'stage' their drug experiences for a desired hallucinogenic effect. MacLean argues that 'chroming enables young people to be in a world as both a person and machine, tracing a trajectory of power invested in those most able to incorporate technologies into their lives' (p. 408). Building upon these insights, in a second article MacLean (2008) examined how pleasure-seeking creates meaning in chroming. In this article, MacLean discusses how 'the pleasures of drug use practised by extremely marginalised people' (p. 376) are not given the same attention as are the pleasure practices of mainstream recreational drug users. She argues that marginalised

young people's drug use is frequently characterised as problematic and indicative of escapism. Furthermore, like Mayock (2005), MacLean examines risk-taking among young people who spoke about balancing costs and benefits while chroming, and were not ignorant of the potential risks and consequences of their consumption. Exploring these issues more broadly, more recent research conducted by MacLean et al. (2013) examined narratives of early teenage alcohol and other drug use. Contrary to popular belief that young adolescent drug use is inherently problematic and uncontrolled, the (13–15-year-old) participants in this study constructed their use as purposeful, generally controlled, likely to be part of their future lives and that they neither required nor would benefit from formal treatment (p. 208). MacLean et al. note that many participant responses from this cohort closely resemble those from older cohorts in similar studies, and that these responses illuminate how the meanings of alcohol and other drug use develop through teenage and young adult years. These studies support the contention that social ostracism, as a consequence of life circumstances and not frequency of drug use, requires the most scrutiny when examining alcohol and other drug use pathways.

In an approach clearly linked to Van der Poel and Van de Mheen's (2006) arguments concerning social pressures and drug use, Foster and Spencer (2013) conducted interviews in Canada aimed at developing a deeper understanding of the role that socialisation plays among recreational marginalised young drug users. Foster and Spencer are critical of research that is limited to quantitative analysis of problematic drug use, as they argue this does not recognise the 'nuanced roles of friends and friendship in a person's engagement with illicit drugs' (p. 225). This study is unique in that the semi-structured interviews did not focus on asking questions about drug use. Instead, Foster and Spencer tailored the interviews to ask the participants about relationships with others and activities they enjoyed, which provided well-received opportunities for respondents to volunteer information about the importance of their drug use. This study highlights how drug use is intrinsically woven into the users' lives and narratives. Furthermore, Foster and Spencer recognise that not all marginalised young people's drug use is problematic or compulsive. Their focus on recreational drug use by marginalised young people suggests that pleasure-seeking is not restricted to the socially integrated 'normal' user. These insights suggest that assertions that inherently link problematic use and marginalised young people fail to address the multiple experiences and understandings of these young people.

Fraser et al.'s (2014) book on addiction contains two chapters of particular relevance to this section. In the first chapter, 'Making methamphetamine in drug policy and consumer accounts' (p. 91) the authors use qualitative data to assess expert accounts on methamphetamine use and addiction from the point of view of the consumers' experiences of the drug. Importantly, the authors find that, despite policy focus on methamphetamine as 'addictive', user accounts cast doubt on and destabilise notions of addiction. In this chapter, the authors argue that 'habit' provides a 'valuable otherwise' (p. 126) to the conventional notion of addiction as it is more subtle and everyday, and allows for better understanding of the multiple elements that affect individual alcohol and other drug practices. The second chapter of relevance, 'Assembling alcohol problems: young people and drinking', explores youth drinking. In this chapter, the authors examine the relationship between research and what they call 'public understandings' of alcohol addiction (p. 165). Fraser et al. examine the multiple elements that contribute to the construction of alcohol addiction and suggest that young people's perceptions are in fact more subtle, nuanced and complex than many of the expert medical and scientific debates on the issue. Again, habit is discussed as an alternative to addiction. Overall, the book asks large questions about the way concepts of addiction drive responses to alcohol and other drug use and other social practices, setting a useful foundation for my own project, which similarly explores the role of such meta-concepts in defining experiences and responses.

In this section I have canvased the relevant literature on the sociology of marginalised alcohol and other drug use among young people. As suggested in the previous section, the literature highlights how marginalised use and users are conceived of in distinct ways from their mainstream counterparts. However, it also shows how often marginalised use is purposeful and pleasurable. Despite there being clear distinctions between how mainstream and marginalised use is conceived, in both instances the literature shows that young people engage in purposeful use and shape their practices as they experience, respond to, and engage with risk.

Australian sociological literature on experiences of treatment

In this section I move on from literature specifically focusing on consumption to look at scholarship on experiences of treatment. Sociological research conducted on Australian alcohol and other drug services and treatment programs is scarce, and studies of the experiences of those who use these services are even more so. In this section, studies

conducted within the past decade on Australian alcohol and other drug treatment experiences are explored, paying particular attention to the scholarship on young people in services (see Foster, Nathan, and Ferry, 2010; Fraser & valentine, 2008; Gourlay, Ricciardelli, & Ridge, 2005; Green, Mitchell, & Bruun, 2013; MacLean, Bruun, & Mallett, 2013; Salter & Breckenridge, 2014; Wilson, Saggers, & Wildy, 2013). Combined, these works comprise the current body of sociological and qualitative literature on treatment studies. These studies demonstrate how varied types of treatment and services help to shape and affect user experiences.

In 2005, Gourlay et al. published findings from a study that linked pre-existing self-conceptions of heroin consumers and methadone maintenance treatment clients to subsequent positive and negative experiences in treatment. Through in-depth interviews, they explored how the personal circumstances of study participants affected their self-conceptions and their experiences of program regulation. Devising three categories of self-conceptions, the 'non-addict', 'functional' and 'conflicted' (p. 224), Gourlay et al. argue that those with resources and supportive networks benefited more substantially from their treatment experiences, while those coping without such resources experienced disempowerment and perceived their methadone consumption as another form of addiction. However, a limitation of Gourley et al.'s analysis is their use of role identity theory, which assumes that the participants are perpetually restricted within their self-conceptions. This study suggests a way to respond to these self-conceptions yet does not allow for the alteration/reproduction of self-conceptions by users themselves. Contrary to this approach, Fraser and valentine (2008) approach methadone maintenance treatment (MMT) as a 'phenomenon' (Barad, 2003). Drawing on in-depth interviews, policy documents and media texts, they argue that MMT is dependent on two opposing images of the consumer: the responsible 'choosing' subject and the victim in 'liquid handcuffs' (Fraser and valentine, 2008, p. 118). Arguing for a reconceptualisation of methadone, they consider the interlocking effects of medical, social, legal and political forces in constructing the substance of methadone itself as well as experiences of the treatment program. Furthermore, they explore how MMT exercises power and helps generate particular subjectivities for clients. Within Fraser and valentine's work, the most relevant aspect for my project is their examination of how MMT addresses and produces particular subjects. However, their study does not focus on young people or youth who are engaged in treatment (MMT or otherwise).

Concerned by the relative lack of research on young people in Australian alcohol and other drug services, and aiming to give adolescents a voice in their own programme evaluations, Foster et al. (2010) conducted four months of participant observations in an adolescent therapeutic community. To learn about the experiences of program participants, the authors explored how group activities and encounters shape interpersonal relationships and treatment journeys. They analysed how particular activities prompt engagement or frustration and suggest a need for a 'more central role for creative and vocational activities in adolescent programs and a variety of ways for them to document their journey' (p. 531). Focusing on the progress of participants' treatment programs, they argue that alcohol and other drug treatment is a series of encounters from which success can be measured irrespective of program completion. While providers try to formulate ways to improve program retention, Foster et al. argue that program retention and completion are inadequate ways to measure treatment success. Also exploring young people's engagement in treatment programs, Green et al. (2013) use a narrative approach to analyse individual and group interviews with service-engaged young people. The authors propose two concepts −'bonding' and 'bridging' (p. 421) − as useful to understand the participants' current and future relationships. Dividing relationships into types, the authors focus on young people's social connectedness and explore whether relationships with friends, family and peers help them meet their needs, maintain emotional health and limit engagement in illegal activities and alcohol and other drug use. They conclude by arguing for a causal link between emotional connectedness, relationship engagement and success in sobriety goals.

Wilson et al. (2013) also investigated youth alcohol and other drug services. Their study explored treatment program activities and young people's participation in and experiences of them. Responding to a relative lack of research on young people's experiences of residential treatment, Wilson et al. used interviews, observation and participation with clients to identify and propose five stages of progress in treatment. Arguing that their narrative approach helps uncover 'what works' in alcohol and other drug treatment, they also assert that when participants share their narratives they create meaning about their drug use and service experiences, 'actively constructing new biographical scripts' (p. 124). Grounding their analysis in a linear model of progression (where a participant can move only forward and backward through the stages) they tend to analyse the 'biographical scripts' and service experiences via a two-dimensional model of progress.

In 2014 MacLean, Kutin, Best, Bruun, and Green published a study of the key notion of 'risk' in young people's alcohol and other drug treatment experiences. Using predominantly quantitative research, the authors compared the risk profiles of 13–15-year-olds with those of older youth (16–19 and 20–24 years). Of especial relevance to my project are the 20 qualitative interviews they conducted with participants in the 13–15-year age bracket. MacLean et al. argue that the findings of these interviews strongly suggest that young people are inclined towards engaging with adults in 'sustained relationships' in the treatment sphere. These adults can help them with a broad range of issues of concern, rather than focusing only on their alcohol and other drug consumption. This point is explored further in this thesis. In another recent study, and similar to the linear model of progression adopted by Wilson et al., Mawson et al. (2015) take up the notion of 'recovery capital' using social identity theory to explore how young people in treatment shape their identities based on their engagement with substance use and the notion of recovery. As the authors elaborate, non-adherence to the values and behaviours of the service consigns people to an 'out-group', while adherence places them in the 'in-group'. Based on this premise, Mawson et al. note that young people in treatment make clear transitions from groups of substance users and into groups with recovery goals. In their article, they explore the tensions of this movement; however, this approach is inadequate because it suggests that young people's self-conceptions are dominated by a singular treatment trajectory. This narrow approach is common in youth treatment studies. Indeed, much of the research conducted in this area is quantitative in nature and focuses on relatively narrow assessments of treatment outcomes and behavioural change. For instance, a recent study conducted by Best and Lubman (2016) adopts this approach. Using fully structured questionnaires, the authors conducted 112 interviews with young people (aged 16–21) at the beginning of treatment and six months later. Comparing these two datasets, the authors identify reductions in reported substance use, and improvements in social functioning, mental health and life satisfaction. However, these findings tell us nothing about individual experiences of these changes. More qualitative research is needed to help explore how young people understand things such as substance use, social functioning, mental health and life satisfaction, and how changes to these are experienced.

The studies discussed thus far examine experiences of alcohol and other drug treatment in a range of ways. With the exception of Fraser and valentine (2008), who discuss gender differences in MMT, and Salter and Breckenridge (2014), who explore the experiences of

female survivors of childhood abuse, gender is largely ignored in this literature. Responding to the 'gender vacuum' in which many alcohol and other drug treatment programs operate, Salter and Breckenridge (2014) focus on women in alcohol and other drug treatment. Within this, they pay specific attention to women who have a history of childhood or domestic abuse. Their study highlights how alcohol and other drug treatment programs overlook and undermine past experiences and compounding factors in alcohol and other drug consumer experiences. They argue that service provision is not gender neutral, but 'should be understood as implicitly gendered in that it neglects the specificity of women's needs in relation to abuse, mental illness and parenting' (p. 165).

The literature I have explored in this section canvasses the scholarly areas of concern in relation to young people's alcohol and other drug use and service contact. This literature examines positive and negative experiences of treatment (Gourlay et al., 2005), effects and experiences of people in treatment programs (Foster et al., 2010; Fraser & valentine, 2008; Wilson et al., 2013), young people's relationships and self-conceptions (Green et al., 2013; MacLean et al., 2013) and issues of gender and exclusion in treatment models (Salter & Breckenridge, 2014). These studies illuminate the multiplicity of treatment experiences; however, they do not explore how young people's perspectives and understandings are in themselves shaped by their treatment experiences. There is some literature that contextualises service experience within individual and social histories and conditions (see in particular Fraser & valentine, 2008; MacLean et al., 2013; Salter & Breckenridge, 2014), but scholarship on marginalised young people's experiences of treatment, especially that exploring how drug harms and notions of 'addiction' are produced, is especially wanting. This is an area to which this thesis aims to contribute.

What is the purpose of policy, and what does it produce?

Thus far, I have explored literature that concerns the sociology of addiction, alcohol and other drug use and treatment. In the following section I examine scholarship that considers policy as its primary interest. Policy is a key area for attention as it is made by multiple inputs and has consequences for the topics it addresses. In this instance, alcohol and other drug policy has direct implications for treatment services. The clients of these services, including the participants of this study, are affected by policy implications and imperatives.

Policy is often claimed to be informed and designed around research evidence (Ritter, 2011). However, some scholars have questioned this assumption by exploring how policy helps to produce the 'problems' it sets out to address. This section is divided into major areas of interest, in which I trace the published literature on alcohol and other drug policy chronologically. Presented first is literature that analyses the purpose and effectiveness of alcohol and other drug policy at national and state levels. It explores the tensions in policy and uncovers what may be missing from policy making processes. Presented second is literature on the type of subjects that policy produces. In particular, this examines the neo-liberal subject and the problematising of alcohol and other drug use. Clearly missing from all of this literature is an analysis of the place of young people in Australia's alcohol and other drug use policy. Although young people are frequently framed in policy as starkly different from adults, little scholarly attention has been paid to this representation. As I explore in this thesis, young people are often conceptualised as unstable and changeable. Similarly, young people's alcohol and other drug use is often conceived of as a temporary problem and a product of making the wrong choices. How the existing research on policy assists us in analysing the effects of this will be considered throughout this section.

Australian alcohol and other drug policies are increasingly analysed for what they aim to achieve. For instance, some researchers ask whether policy is effective in tracking and reducing harms associated with alcohol and other drug use (Loxley et al., 2005; Ritter & Cameron, 2006). Others argue that moral judgements are embedded in policy outcomes (Ritter, 2009; Ritter & Bammer, 2010; Ritter, 2011; Lancaster, 2014; Lancaster, Santana, Madden, & Ritter, 2015). Drawing on a range of theoretical frameworks, scholars have sought to examine the intentions and competing forces embodied in Australian alcohol and other drug policies.

Loxley et al. (2005) examined intentions and forces while analysing alcohol policy options for their effectiveness in reducing harm. They argue that the national consensus on Australia's approach to alcohol use is absent from its approach to other drug use. In particular, they note the seven policy options that influence the use of alcohol in the community:

> Pricing and taxation; regulating the physical availability of alcohol; modifying the drinking context; drink driving countermeasures; regulating alcohol promotion; education and persuasion strategies (in communities, homes, schools and work-places) and treatment and early intervention. (p. 560)

In relation to the final point, Loxley et al. (2005) argue that screening and early brief intervention is a cost effective, broadly applicable way of treating 'early-stage problem drinking, thus obviating the need for later more intense treatment' (p. 565). They suggest that these early interventions and treatment modes are particularly suitable for high-risk populations, such as young men. They conclude that the key issue for alcohol policy is to address high levels of consumption and ensuing harm. These issues are often taken up and addressed in policy approaches to harm reduction for alcohol and other drug use.

Indeed, a discussion of harm reduction has proved an effective way of approaching issues concerning consumption and harm. Ritter and Cameron (2006) review the efficacy and effectiveness of alcohol, tobacco and other drug harm reduction interventions, and identify evidence to support harm reduction in illicit drug policy. Ritter's (2009) analysis of policy decisions reiterates this support. Here, Ritter argues that policy evolves from more than just research evidence; influences such as 'politics, power and pressure groups and opportunistic policy windows' all contribute to policy-making decisions (p. 70). This demonstrates the complexity of the policy making process and identifies how moral judgements are embedded in policy outcomes. Ritter and Bammer (2010) also examine how policy is made, and outline the challenges of integrating the findings of academic research in the policy making process. In this article, they explain five prominent models of policy making (incrementalism, the technical/rational model, models about power and interest groups, the advocacy coalition framework and the multiple streams model) as a means of educating researchers on the processes that Australian policy makers use. Ritter (2011) takes up similar arguments and explains that:

> A whole of government approach is required across multiple government actors; that politics influences drug policy, but there has been a level of stability in drug policy that belies its emotive content; that public opinion on drug policy is less driven by coherent ideology, and more by pragmatic responses; and that decision makers rarely

> access academic literature and use research in instrumental and symbolic ways. (p. 152)

These comments highlights the problematic nature of illicit drug policy and the multiple influences that policy makers encounter.

In Chapter Four, Australian and Victorian policy approaches to alcohol and other drug use, addiction, treatment, marginalisation and youth are explored. In these analyses, I refer to the foundations put in place by Fraser and Moore (2011), who, drawing on Bacchi (2009), demonstrate that a theoretical lens shapes the method of analysis. Additionally, two years later Moore and Fraser, this time drawing on Marrati (2006), analyse how 'addiction is conceived in policy as a bounded problem, a condition that can be treated in isolation from other problems', showing that the 'problems' of alcohol and other drug use are made and attributed in the policy making process (Moore & Fraser, 2013, p. 916). Lancaster (2014) adopts this approach in a response to the recent focus on evidence-based policy and offers a social constructionist approach to alcohol and other drug policy analysis. Also drawing on the work of Bacchi (2009), Lancaster (2014) suggests 'a turn from "problem solving" to "problem questioning"' in policy analysis, (p. 949). Noting that evidence is only one part of making policy, Lancaster questions assumptions about evidence as fixed and stable, and considers its use in the policy making process. In recognising the multiple voices and knowledge(s) that go into policy making, Lancaster argues that it may be easier to identify avenues for reform. Similar findings came out of Lancaster and Ritter's (2014) collaborative work that examined Australia's five *National Drug Strategy* policy documents (1985–2010). Lancaster and Ritter (2014) again draw on Bacchi's (2009) analytical framework. In this work, they consider how the 'problem' of drugs is presented in these policy documents. They argue that by analysing these documents 'we begin to see the significant role that evidence, expert opinion and data play in constructing and representing the problem of drugs in these policy documents' (Lancaster & Ritter, 2014, p. 83). Importantly, they find that the 'problem of drugs' in these documents has shifted significantly over time. The language used in the policy documents both describes and makes 'drug problems' in policy. Subsequently, Lancaster et al. (2015) note that policy creates stigma against people who inject drugs and in turn shapes how they feel about and respond to policy.

This literature starts from the observation that policy is a collection of ideas formed by multiple factors, including public values, budgetary imperatives, and ideology. Its findings suggest particular ways that we can analyse how policy affects young people's experiences, such as how the 'problems' of alcohol and other drug use are made and attributed in the policy making process (Fraser & Moore, 2011; Moore & Fraser, 2013). Some of the literature explored here considers how harm reduction imperatives are taken up in policy documents (Loxley et al., 2005; Ritter & Cameron, 2006). Focusing on harm reducing strategies can serve to define alcohol and other drug use as inherently harmful, thereby denying the pleasures that some people enjoy and the role alcohol and other drugs have in society generally (Moore, 2008). Additionally, scholars have observed that policy works to produce particular kinds of subjects (Fraser & Moore, 2011, Moore & Fraser, 2013), and in looking at how policy encourages the notion of harm in alcohol and other drug use, some scholars (Fraser & Moore, 2011; Lancaster, 2014; Lancaster & Ritter, 2014) analyse this problematising of alcohol and other drug consumption. In the next section of the literature review I take up these ideas and show how certain groups, particularly marginalised people, more readily experience attributions of alcohol and other drug problems.
As considered above, alcohol and other drug policy is both a product of multiple inputs (e.g., public values, budgetary imperatives, and ideology) and a producer of multiple outcomes (e.g., drug and alcohol harm and notions of addiction). The literature below explores the intended and unintended effects of alcohol and other drug policy, focusing on the types of subject that policies produce and looks at how addiction is made.

Utilising data collected for their study of street-based drug users and sex workers in a Melbourne suburb, Moore and Dietze (2005) highlight how Australia's alcohol and other drug policy shapes experiences of harm. Drawing on Rhodes' (2002, 2005) 'risk environment' framework, the authors persuasively argue that 'Australian drug policy and practice should be re-framed so that its primary aim is the creation of "enabling environments" for the reduction of drug-related harm' (Moore & Dietze, 2005, p. 276). An enabling environment approach (Rhodes, 2002) 'seeks to alleviate the situational and structural conditions of risk and vulnerability [so] it is essentially at once a human rights approach to the alleviation of harm' (p. 92). Additionally, Moore and Dietze identify how as a result of the Australian political system, in which states have primary responsibility for drug policy and practice, discrepancies arise in how these policies are enacted across Australian states, such as in needle and syringe programs. As Ritter and Cameron (2006) did,

Moore and Dietze (2005) identify how policy-driven harm reduction ideals are endorsed and enacted differently across states and services.

Moore and Fraser (2006) added a new dimension to the exploration of Australian alcohol and other drug policy and the subjects it enacts. Conducting a 'poststructuralist analysis of the cultural inscription of drug-using subjects in the neo-liberal discourses of contemporary harm reduction' (p. 3035), they note the effect that shifts to neo-liberal governmentality have on health promotion. In this context, they argue, 'risk is redistributed from the state to individuals' (p. 3037). Individuals are expected to make 'healthy choices', and this expectation hinges upon the assumption of a common rationality. Moore and Fraser argue that stigmatised groups (such as injecting drug users) are often construed as behaving irrationally (ibid.). Other stigmatised and marginalised groups are conceived in similar ways. For instance, I suggest that marginalised young people who use drugs may be conceived as 'irrational' if they 'fail' to make healthy choices. Moore and Dietze (2005) as well as Moore and Fraser (2006) draw attention to how policy makes distinctions between types of alcohol and other drug users based on preconceived notions of choice, rationality and risk. Further distinctions are made in policy by drug use type, and, as I will demonstrate in Chapter Four, between substance consumers based on age and socioeconomic status.

As Ritter (2009, 2011) has argued, evidence is only one of many inputs to the policy making process (Moore & Fraser, 2013). Valentine (2009) explored the 'relationship between evidence and policy in the domain of pharmacotherapies treatment' (p. 447). In her analysis of state management of alcohol and other drug treatment, valentine argues that standardised measures of treatment outcomes are too narrow. Instead, she advocates 'a critical values-based approach [that] directs us to questions of political power, ideology and the marginalisation of drug users' (p. 460) whereby the environments and systems that perpetuate individual vulnerability to harms gain more attention than the social functioning of the client. Building on earlier studies that consider the types of subjects and ideals that alcohol and other drug policy produces, Keane (2009) explores the 'gap between public health conceptions of intoxication as harm and the experience of bodily pleasure valued by many drinkers' (p. 136). Taking the *Australian National Alcohol Strategy* (Ministerial Council on Drug Strategy, 2006) as a starting point, Keane (2009) argues that intoxication cannot be reduced to this binary. It is, she argues, 'embodied, social and situational rather than an abstract and universal category with a fixed meaning' (p. 141). This contextual understanding of

intoxication, harm and pleasure is also taken up by Duff (2010). Drawing on Moore and Dietze's (2005) earlier work utilising Rhode's risk environment framework, Duff (2010) suggests that products of policy, such as needle and syringe programs and drug education programs, need to be more 'concerned with the most immediate aspects of drug users' lived experiences' (p. 343). Certainly, much of the literature that considers Australian alcohol and other drug policy suggests that the context of alcohol and other drug use is considered in these policy documents only minimally. Duff applies the notion of 'place' (as made through human interaction) to analyse risk and enabling environments, arguing a focus on place 'emphasises the ways such environments are made and remade in practice and interaction' (p. 338). Studying the physical and social setting of consumption exposes biases, preferences and assumptions that circulate within alcohol and other drug use policy discourses. More importantly, Duff argues, it offers insights into the ways people formulate meaning about their use, within the context of their lived experiences.

In looking at how addiction is made in alcohol and other drug policy, it is useful to draw on Moore and Fraser's (2013) article that explores how the 'addiction problem' is produced as a bounded disease which can be addressed through an episode-of-care system. Drawing on Marrati's (2006) work, this piece analyses interviews with Australian policy-makers and practitioners. According to Moore and Fraser, Victorian alcohol and other drug policy quantifies and funds interactions between service users and providers via categories of 'dependence'. They identify six unintended consequences of this approach: 'It rewards gaming, encourages fragmented provision, undermines long-term support, restricts treatment services in ways that might not be in the best interests of service users, ignores non-drug issues, and marginalises those with multiple needs' (p. 921).

These consequences highlight the importance of recognising alcohol and other drug treatment and the policy on which is it based as a complex interaction that can create, exacerbate, or force individuals to adopt diagnoses for the very problems it aims to reduce. More recently, Fraser (2015) published findings from a qualitative analysis of Australian and Canadian alcohol and other drug policy. Drawing on interviews with policy makers, service providers and advocates, Fraser explores how addiction is conceptualised across these settings. As will be discussed in more detail throughout Chapter Three, in Australian policy addiction is often presented (albeit through multiple models) as a stable fact. Taking up one of Fraser's examples, addiction is at times conceived to be caused by past trauma or abuse. As Fraser

observes, ‘if the causes of addiction lie in trauma, psychic pain, poor social conditions and a need for self-medication, addiction can be considered an effect of other, more fundamental ills’ (p. 6). Some policy makers, and maybe even some alcohol and other drug users, may find this approach helpful as it realigns attention from their alcohol and other drug use to other, perhaps more pressing life challenges. This example may be especially pertinent to those experiencing marginalisation. However, as Fraser also argues, ‘for those who resist the idea that their drug use, even if regular or what they or others call addiction, is a pathological phenomenon – something that signals or manifests their psychic disease – it can be […] less persuasive’ (p. 6). This account argues against addiction as a disease or other pathological affliction, critiquing the rise of such approaches in Australian policy.

In a cross-national study, Moore, Fraser, Törrönen, and Eriksson Tinghög (2015) analysed and compared Swedish and Australian drug policy, looking at treatments of addiction, social exclusion, and gender. In their analysis of the Australian *National Drug Strategy 2012–15* (2011) they note that although it avoids the use of the term ‘addiction’, ‘it retains many of its pathologising and marginalising implications in its evocation of ideas of experimentation, trauma and vulnerability’ (Moore et al., 2015, p. 423). They add that addiction and social exclusion (along with gender) help to constitute one another. Certainly, in the *Strategy*, notions of social exclusion and marginalisation are taken up as both causes and effects of problematic alcohol and other drug use. Further analysis of this policy is presented in Chapter Three.

In much of the literature presented here, scholars repeatedly call for policy makers to acknowledge the complexity of alcohol and other drug-use experiences. Similarly, they call for recognition that policies constitute and produce the problems they seek to address. Several key themes are present in this literature. Firstly, discrepancies in alcohol and other drug policy enactment across states are identified (Loxley et al., 2005; Moore & Dietze, 2005; Ritter, 2009; Ritter & Cameron, 2006). Secondly, there is tension concerning the neo-liberal subject and rationality in drug-using subjects (Fraser and valentine, 2008; Moore, 2008; Moore & Fraser, 2006, 2008). Thirdly, evidence-based policy is a product of multiple influences (Ritter, 2009, 2011; Ritter & Bammer, 2010) and policy attempts to quantify alcohol and other drug treatment outcomes create unintended effects (Moore & Fraser, 2013). Scholars in this field use multiple theoretical frameworks for their analyses, such as Rhodes’ risk environment (Duff, 2010; Moore & Dietze, 2005) and Bacchi’s ‘What’s the Problem

Represented to be?' (WPR) approach (Fraser & Moore, 2011; Lancaster, 2014; Lancaster & Ritter, 2014). Overall, these analyses enable us to actively consider how 'addiction and modern society have made each other' (Fraser & Moore, 2011, p. 40)), and in this particular context, the role policies play in producing alcohol and other drug problems and addiction.

Conclusions

In this review I examined a range of literatures to establish the basis for my project. I began with the sociological literature on addiction, then moved to young people's alcohol and other drug use, their contact with treatment services and alcohol and other drug policy. In the first section I discussed contemporary literature on addiction concepts, finding a strong emphasis on the need to understand addiction not as a static illness or affliction, but as a progressively developed assemblage of ideas with multiple meanings. Next, I explored the literature on mainstream and marginalised alcohol and other drug use. The literature suggests that marginalised young people's consumption practices are often problematised differently to the consumption practices of their mainstream counterparts. In the third section I focused on studies that explore service experiences, in particular young people's experiences in Australia. I highlighted how service contact helps shape consumer experiences and conceptions of the self. Most importantly, these texts help to question the ways the figures of the 'user' and the 'addict', and of the 'successful treatment client' are produced through treatment programs. They also refer to the ways that people take up and/or resist these notions. Given that these concepts circulate widely in popular discourse as well as in health and criminal justice settings, we must ask how individual drug users and those who receive a diagnosis of addiction or dependence understand these terms and their relevance to themselves. As noted in *The sociology of addiction* section, consumer narratives of addiction have been explored before (e.g., Fraser et al., 2014; Keane, 2001; Summerson Carr, 2011). However, it is evident that much research remains to be done to illuminate consumer perspectives on addiction as a direct consequence of their contact with services, especially for marginalised young people. My research project is intended to address this gap with an analysis of the representations of marginalised youth alcohol and other drug consumption in Australian and Victorian alcohol and other drug policies, and through qualitative research with marginalised young alcohol and other drug consumers who have had contact with treatment services. I consider how service discourses relate to their own understandings of

use and ‘addiction’, and to their personal aspirations and priorities for treatment and for their lives more broadly.

In the later parts of this chapter I took up policy analysis as a primary focus. I found a range of literature that analyses what goes into producing policy, explores the tensions in policy and uncovers what may be missing from policy making processes. Equally importantly, I explored the literature on the types of subjects that policy produces – in particular, the neo-liberal subject and the problematising of alcohol and other drug use. The literature highlights that types of environments – social, physical and policy – all work to constitute and produce the problems that they seek to address. In turn, this actually shapes and makes the risks that people operating in these environments encounter.

Chapter Three: Approach and Methodology

The conduct of social research rests on the researchers' adopted theoretical and methodological approaches. In this chapter, I establish the theoretical and methodological orientation of this thesis. I begin with an overview of the shift from a traditional account of knowledge to a poststructuralist theoretical approach. Ideas of poststructuralism, which are taken up and utilised in the subsequent analysis, are introduced. Also included is a brief introduction to how I conceive of the notion of risk. In order to move away from reductionist approaches to risk as synonymous with prospects of harm, I draw on the work of Mary Douglas (2013) to elaborate a notion of risk in terms of positive and negative chance. With these theoretical foundations in place, Rhodes' (2002, 2009) 'risk environment' approach is examined. The 'risk environment' framework categorises environments into types and levels. Adopting such a context-based theoretical approach enables the exploration of how positive and negative risk is produced and experienced in alcohol and other drug service contact.

The second half of this chapter is dedicated to the methods adopted for this research. In it, I identify the key features of qualitative research. Beginning with an introduction to the purpose of social research, the suitability of a qualitative methodology for this research is explored. A discussion of the semi-structured interview method, and the use of case studies, follows. Finally, the chapter details processes and considerations for collecting and analysing the data. This involves a thorough explanation of the specific techniques used and the ethical considerations in involving marginalised young alcohol and other drug consumers in social research.

Poststructuralist approaches

The study of society, or social research, is a concept that emerged during the Enlightenment. A prevailing philosophical idea of this era was the belief in a stable and reliable scientific process. This approach understands the scientist (or researcher) as an objective, unbiased observer. Furthermore, it assumes that the scientist observes an objective reality and systematically test hypotheses in order to discover knowledge and truth. This view of scientific knowledge and methods as independent, objective and value-free is known as positivism. Despite initial successes, more recently positivist epistemology has attracted substantial criticism. Scholars from a range of disciplines have challenged 'the idea that scientists can be as objective as the positivistic ideal assumes' (Babbie, 2010, p. 42). Scientific knowledge is never value-free. Scientists bring their own cultural expectations,

world views and biases to the processes of formulating their ideas on what to study and to the processes of collecting their observations and measurements. As Marvasti (2004) notes, when utilised in social research fields a positivist epistemology confuses popular opinion and common sense with the truth, which makes its assumptions of objective, pre-existing phenomena insufficiently critical and 'theoretically vacuous' (p. 6). Moving towards a post-positivist approach, Rhodes and Coomber (2010), writing in the drugs field, are similarly critical of positivism and argue that:

> It is a naïve and fallacious claim of positivism to hold on to the idea that research on human behaviour can be objective and value free, and that certain methodological approaches give unmediated access to capturing the 'truth' of drug use or addiction. (p. 74)

Knowledge of drug use and addiction are not unchangeable facts, Rhodes and Coomber (2010) suggest, but continually developing ideas. These ideas recognise that because scientific knowledges and methods are biased and fallible and there are multiple perspectives, we can never know the world with any certainty. However, post-positivism still retains a foundational belief in an independent reality that pre-exists our attempts to know it.

Since the 1960s, the belief in a single reality, such as seen in positivism and post-positivism, has been challenged by scholars working within what has come to be termed poststructuralism (Buchanan, 2010). Poststructuralism questions any claims to authority and essential truth. It holds that our understandings and knowledge of the world are never free of the social conditions under which they are produced. As Williams (2005) writes, this movement gave rise to a:

> Thorough disruption of our secure sense of meaning and reference in language, of our understanding of our senses and of the arts, of our understanding of identity, of our sense of history and of its own role in the present, and of our understanding of language as something free of the work of the unconscious. (p. 3)

Here, Williams draws attention to poststructuralist approaches to the production of power and meaning through the use of language and discourse. This is an integral part of poststructuralist analysis, but mention must also be made of the role that the subject and

subjectivity play in this theory. Simply stated, poststructuralist theorists are concerned with language, discourse and subjectivity.

Just as Williams draws attention to language, Weedon (1997) argues, in her book *Feminist Practice and Poststructuralist Theory*, that it is through language that 'actual and possible forms of social organisation' – institutions and social, cultural and political ideas about the world – are defined and challenged (pp. 21-22). As Weedon suggests, from a poststructuralist perspective language is generative. Accordingly, knowledge, and the language it is enacted through, are not understood as singular coherent systems and practices, nor as transparent windows into reality. Sarantakos (2005) explains that:

> Knowledge is pluralistic and dominated by an inherent diversity, ephemeracy, fragmentation and ambiguity; depends on social and cultural conditions, discourses, belief systems, interpretative models, language systems and power systems… and is socially constructed. (p. 316)

Static definitions are redundant in this approach, and any discovery of meaning remains relevant only for the moment in which it is discovered. As mentioned above, poststructuralists are also concerned with subjectivity; this is defined as unconscious and conscious thoughts, ideas and emotions, the way someone understands themselves and how they see themselves to be situated in relation to society and the world (Weedon, 1997). Weedon argues that our subjectivity is also constructed through language. This 'implies that [subjectivity] is not innate, not genetically determined, but socially produced' (p. 21). Rather than the humanist rational, unified subject (seen in the traditional approaches of Enlightenment positivism discussed above), poststructuralism understands subjectivity as a site of disunity and conflict (p. 21).

Weedon (1997) provides an analysis of the inextricable connection between discourse and power. She examines, for example, how unequal power relations are produced and reproduced through patriarchal discourse. Furthermore, she shows how the language we use helps to shape our own subjectivities, and how this can serve to perpetuate inequality. Weedon provides examples of exclusions and subjectification in the language at work through the criminal justice system's approach to female and male gender. As noted above, language is central to the poststructuralist concept of discourse. For poststructuralists,

discourse is more than words said; it is the body of language that is unified by common assumptions. Discourse gives meaning to the world, social processes and relations (Weedon, 1997), and it helps us to understand the meanings of practices and subjectivity. When meaning is understood as created through discourse, there can be no universal truth, as 'truth can never be separated from the system that produced it or removed from the functions of regulatory statements' (Koro-Ljungberg, 2008, p. 222). Through discourses, we see the production of knowledge and the exercise of power that, for poststructuralists, are inseparable (Martin & Stenner, 2004). As will be shown in later chapters, the concept of discourse is a key element of my study's methodology. I draw on Jäger and Maier's (2009) approach to discourse analysis: 'Discourse, with its recurring contents, symbols and strategies, leads to the emergence and solidification of 'knowledge' and therefore has sustained effects. What is important is not the single text … but the constant repetition of statements' (p. 38). This approach incorporates what is 'said' and the context in which it is situated. Thus, what is important is not just what young people express about alcohol and other drug use and addiction, but also the discursive environment, or *context*, in which they express it.

The conceptual ideas outlined above can be applied to marginalised youth and current discourses on addiction and other risks and harms of drug use. Young people are produced as vulnerable risk-takers in many public health and harm reduction discourses. In Chapter Four, I analyse these discourses as they appear in key national and state policy documents. In these texts, young people are clearly articulated as both at risk of harm and as instigators of risky activities. How these ideas are taken up and enacted in treatment settings is closely explored in Chapters Five and Six.

What is risk?

> *Risk* (definition):
> Noun: A situation involving exposure to danger. [in *singular*] The possibility that something unpleasant or unwelcome will happen. [with *modifier*] A person or thing regarded as a threat or likely source of danger. [usually risks] A possibility of harm or damage against which something is insured. [with *adjective*] A person or thing regarded as likely to turn out well or badly in a particular context or respect. [*mass noun*] The possibility of financial loss.
> Verb: [with *object*] Expose (someone or something valued) to danger, harm, or loss. Act in such a way as to bring about the possibility of (an unpleasant or unwelcome

> event). Incur the chance of unfortunate consequences by engaging in (an action). (Oxford University Press, 2017)

In essence, the concept of risk is bound up with danger, harm and loss. But what does this mean in terms of the ways that we operationalise risk? In Chapter Four, I explore how national and state alcohol and other drug policies constitute young people as risky subjects, including the *National Drug Strategy's* (MCDS, 2011) claim concerning 'the adolescent drive to take risks' (p. 6). As Crowe (2016) notes in her critique of Victoria's Secure Welfare Services (SWS), 'what information is provided on risk in legislation and policy is process driven and presents the child as risky as well as at risk of harm' (p. 6). Later, in Chapters Five and Six, I explore the effects of these preconceptions in young people's alcohol and other drug using and treatment narratives. Do policy and treatment approaches suggest there is a predisposition for young people to engage with dangerous activities and incur harm, or is there more to consider when analysing risk? Drawing on the anthropological work of Mary Douglas (2013), I suggest that there is. In her opening comments in *Risk and Blame,* Douglas refers to the common anthropological theme: 'in all places at all times the universe is moralised and politicised' (p. 5). She goes on to explain, what we experience is an 'overt politicisation of risk' (p. 10). By this she means that in calculating risk, we create and attribute risk in a process of blame in order to constitute and distribute personal liability. In attributing risk, we blame people for not being more risk averse. If people do not take the necessary steps to actively avoid risk, they are judged as negligent and liable. However, despite such emphasis on evading it, it appears that risk is everywhere, and that individuals do not necessarily take up injunctions to avoid it.

> The baffling behaviour of the public, in refusing to buy flood-plain or earthquake insurance, in crossing dangerous roads, driving non-roadworthy vehicles, buying accident provoking gadgets for the home, and not listening to the education on risks, all that continues as before. (Douglas, 1992, p. 11)

If earthquake or flood represents exposure to danger, harm and loss, unresponsive homeowners therefore prefer to engage with risk instead of risk aversion. In this way only two options (to engage with or avoid risk) are constructed. In relation to my research focus in this thesis, the illegality of alcohol (with respect to alcohol consumption for people under 18 years, drinking alcohol in public places, etc.) and other drug use means the locations in which

consumption occurs are subject to scrutiny. If policing of these areas increases, so too does the risk of arrest and incarceration. However, if these places are not monitored then other risks arise, such as lack of help in instances of overdose, exposure to violence, other health concerns, and sanitation. If we recognise that many cases offer no avoidance of risk, then the responsibility for engaging with risk takes a turn away from victim blaming. As Rhodes (2002) argues:

> Shifting the unit of analysis and agent of change from individuals, and individual risk behaviour, to environments, shifts how we think about *responsibility for harm* (emphasis in original) – from constituting individuals alone as responsible for their behaviour to tackling socio-political situations and structures in which individuals find themselves. (p. 88)

These considerations highlight the contingent and socially circumscribed nature of alcohol and other drug use practices, in which safeguarding against every possibility is not a feasible option. As Douglas (1992) notes:

> Protecting against one category of risk exposes to another. For example, preventing risks of fire or riot requires open access to the premises; but risks of stolen information call for restricted access: you can have one, or the other, but not both. (p. 14)

Complete risk avoidance is an unobtainable ideal, and each environment in which we operate constitutes its own set of unavoidable risks. The question should not therefore be: will I be exposed to risk? Instead, we must ask: how will I encounter and negotiate risk? How this relates to youth, and especially those who engage in alcohol and other drug use, is part of my theoretical focus. In the section below I discuss how Rhodes' risk environment framework is adapted in this study.

Risk environments

As noted in Chapter Two, the literature shows that alcohol and other drug use among marginalised young people is often conceived in terms of risks and harms, and their own perceptions of their use have been insufficiently explored. My research project addresses this gap through a thorough examination of marginalised young people's alcohol and other drug

use, and it does so by drawing on the risk environment theoretical framework developed by Tim Rhodes (2002, 2009). Critical of public health approaches that view harm as determined by individual action and focus on individual behaviour change, Rhodes (2002) argues that such 'context free' approaches fail to appreciate that risk is dependent on situation and context (p. 86). Rhodes criticises dominant models of individual action ('rational decision-making' and 'reasoned action') which overlook risk-related structural forces and power inequalities (ibid.). He argues that 'At its crudest, individual action and decision-making theories [sic] assume a shared, even single, rationality of risk avoidance, wherein rational behaviour is viewed as synonymous with risk avoidance' (ibid.). However, as he points out, rational behaviour, and indeed, what is considered 'rational', are subject to interpretation and contingent on social context. There is no single rationality, but multiple constructions of rationality in varying logics and meanings that constantly evolve in social environments.

Rhodes argues that adopting the risk environment as a unit of analysis allows a shift away from viewing individuals as solely responsible for harm to include the social situations and structures that produce harm. Developing this approach, Rhodes (2009) argues that the environment may be analytically divided into four 'ideal' types – physical, social, economic and policy. In some work, he describes three ideal levels of environmental influence – micro, meso and macro (Rhodes et al., 2005) – but elsewhere discusses only two – micro and macro (Rhodes, 2009). The micro environment is concerned with the direct effects these four types of environments have on the individuals within them and refers to such things as interpersonal relations and practices, social, group and institutional norms, or the immediate social settings in which alcohol and other drug use occurs. The macro environment refers to broader forces that prompt development in the micro environment and considers material and social inequalities, public and expert discourses of alcohol and other drug use, legal frameworks, and health, drug, welfare and economic policies. As Rhodes argues (2002), risk is produced through the 'inextricable' intersections of the levels of influence across different types of environment (p. 90). Therefore, a 'risk environment is continually made and remade both through and between social structures' (Rhodes, 2009, p. 193). Harm is created by environments and not by individuals alone. From this point of view, marginalised young alcohol and other drug users cannot be seen simply as *instigators* of harmful practices. Attempts to characterise them as inherently problematic do not recognise the impact that social and political forces have on the production of harm.

A risk environment approach challenges perceptions that alcohol and other drug use and addiction are problems located within the individual, reflective of individual failings. These assumptions are frequently adopted in public health and drug treatment approaches that see the solution as based on altering individual behaviour (Rhodes, 2002). According to Rhodes, the risks that young people face when consuming alcohol and other drugs are less a result of the substances they consume, and more a function of the macro and micro environments within which they are consumed. Importantly, this approach does not deny marginalised young alcohol and other drug users all responsibility for reducing harm in risk environments, but as Rhodes explains, harm must be seen as produced through the structures that seek to control or reduce it, and its meaning is dependent on social context.

The risk environment approach facilitates my research on marginalised young alcohol and other drug users as it identifies environments as producers of harm associated with young people's drug use and recognises the structural forces that shape harm and risk. These insights allow me to consider how structural forces are accommodated or challenged in user narratives and the role of policy and services themselves in shaping risk. In particular, the central focus of my analysis is on policy and policy enacted by treatment providers, and not on more structural aspects. Importantly, the risk environment approach overlaps with other key theoretical approaches to drug harms and addiction. Social epidemiology, political economy, situated rationality, governmentality and logics of practice all differ from each other (Rhodes, 2009), yet all agree that harm is constituted through intersections of micro and macro social, structural and political forces. This approach is also useful for this project in that discourses of harm and risk help regulate individual practice and frame individual agency. The risk environment approach helps to untangle the complexities of the circumstances in which marginalised young alcohol and other drug users survive, the construction of their ideas about alcohol and other drugs (both positive and negative), their experiences and encounters within treatment settings, and how their thinking and practices are affected by dynamic structural forces.

Importantly, a theory that helps us understand risk as environmental also enables investigation of safety and pleasure as environmental. This opens up possibilities for considering ways in which environments may be enabling or nurturing. As Mary Douglas (2013) explains, risk traditionally had both negative and positive connotations. This theory reminds us that outcomes of alcohol and other drug use are not simply the effects of

individual characteristics or conduct, but a culmination of influences that all need to be considered together and can be both positive and negative. This framework moves beyond a focus on the individual as responsible for harm to consider the ways in which the interactions between young people and their physical, social, economic and policy environments are implicated in the production of both harm and safety. As such, this framework aids research on marginalised young alcohol and other drug users, and it also invites consideration of how structural forces are accommodated or challenged in user perspectives and experiences.

Although the risk environment framework is important for giving 'primacy to *context* [emphasis in original] when understanding and reducing […] harm' (Rhodes, 2009, p. 193), there is a sense in which this framework may be seen as treating individuals and environments as pre-existing and stable phenomena that interact with one another to produce risk (or enabling) environments. Poststructuralist critiques of objectivity and independence invite us to extend the risk environment theoretical framework with the understanding that individuals and environments are mutually constructed (through language, discourse and practices) and that these processes of construction are ongoing (Fraser, 2015). An example of poststructuralist ideas applied to concepts of the environment is provided by Duff (2007, 2011). Critical of the way that environment is often treated simply as background to drug harms and risks, Duff (2007) offers a new way to approach context as 'an *assemblage of relations* [emphasis in original] drawing together diverse experiences of space and spatialisation; embodiment and becoming; conduct and social practices' (p. 504). Here, individuals and environments are understood to co-produce each other. Importantly, this process of co-production is held to be an ongoing process of enactment. By being sensitive to the locally contingent and emergent character of individuals and environments, these approaches usefully extend Rhodes' risk environment framework (it is worth noting that in later work, Rhodes also takes up these poststructuralist ideas, e.g., Harris, Rhodes, & Martin, 2013; Rhodes, Harris, & Martin, 2013).

Poststructuralist qualitative researchers are interested in how subjects and settings arrange themselves together, how individuals make sense of their surroundings and how these arrangements produce people themselves. According to Marshall and Rossman (2010), 'historically[,] qualitative methodologists have described three major purposes for research: *to explore, explain,* or *describe* the phenomena of interest' (p. 33). This demonstrates, at a basic level, how qualitative researchers use language to explore phenomena. However, as

they further elaborate, ‘these traditional discussions of purpose… do not mention action, advocacy, empowerment, or emancipation−the purposes often found in studies grounded in critical, feminist, or postmodern assumptions’ (ibid.). Therefore, my project, which focuses on marginalised young people and attributions of addiction from a poststructuralist perspective, moves beyond the traditional identifications of purpose. As the final ‘product’ of my research, I aim to provide ‘an alternative set of representations’ (Maher, 1997, p. 232) that challenge popular discourses concerning young alcohol and other drug consumers and assumed relationships between service use and addiction.

Qualitative methodologies

The study of social, cultural and/or environmental phenomena can present a daunting challenge. However, the tools and processes used by social scientists provide both method and structure. Indeed, social research has been defined by Sarantakos (2005) as:

> Purposive and rigorous investigation that aims to generate new knowledge. It is the intellectual tool of social scientists, which allows them to enter contexts of personal and/or public interest that are unknown to them, and to search for answers to their questions. (p. 4)

The conduct of social research can involve the use of either quantitative or qualitative methodologies. In the broadest sense, quantitative approaches to research are concerned with measurement – ascertaining the number or amount of a phenomenon and characterising the statistical relationships between those and other quantities of interest or their effect on the phenomenon over time. These approaches rely on pre-defined variables of interest and categories, and employ data-gathering techniques such as surveys and structured interviews. Qualitative approaches, on the other hand, seek to explore the qualities or character of phenomena. Here, the interest lies with the perspectives of participants, their meanings and interpretations, and the contexts in which a phenomenon occurs (Punch, 2014). Qualitative research uses data-gathering techniques such as field observations, focus groups, textual analysis and semi-structured or unstructured interviews.

Selecting a method, and deciding between qualitative and quantitative research, depends on many considerations. According to Marvasti (2004) ‘choosing a research method is not about deciding right from wrong, or truth from falsehood; instead, the goal should be to select an

approach that is suitable for the task at hand' (p. 12). For my purposes, qualitative methods are more suitable than quantitative as I seek to explore meanings and understandings of particular themes (alcohol and other drug use and addiction). My use of a qualitative methodology draws on theory that rejects the notion of a subject with an essentialist core and also accepts that the interview itself is an 'assemblage' (Mazzei, 2013, p. 735). Thus, the qualitative interview and its subsequent transcript is a site of performance and not simply representative of individual 'lived experience' (p. 737). Hence, I adopt a qualitative approach that moves beyond the individual and contextualises experience and perspective in their broader material and discursive environments.

The objectives of this research are to explore how young people articulate their alcohol and other drug use, and addiction, and how they come to discuss it in those ways. Qualitative research is useful in this regard, as it is able to uncover and explore previously unconsidered phenomena (such as those on which I focus) (Marshall & Rossman, 2010). Expanding on this explanation, Berg (1995) emphasises the importance of setting and argues that qualitative research is able to examine social and cultural settings and those who inhabit them. Specifically in relation to drug use, Rhodes and Coomber (2010) argue that 'We need qualitative research to understand how drug use and addiction have a social basis. We need qualitative research to capture how drug use and addiction are lived, and how such lived experiences can differ according to social context' (p. 59).

Qualitative methods offer capabilities for the researcher to capture the lived experiences of people who use alcohol and other drugs as they are situated within different social, cultural and environmental spheres. Furthermore, qualitative research resonates especially well with alcohol and other drug and addiction research as it is able to encompass the varied elements that combine to produce discourses of alcohol and other drug use and addiction. Rhodes and Coomber (2010) criticise methods that fail to appreciate how 'lived experience impacts on the nature of drug use and addiction' as they understand drug use and addiction as '*context-based* phenomena which are *socially situated',* varying according to time and place (emphasis in original) (p. 73). They go on to argue that qualitative researchers are able to develop an understanding, based on interpretation, of what alcohol and other drug use can mean. The use of qualitative research methods enables the exploration of participant narratives concerning 'individual experiences, peer influences, culture or belief' (Rich &

Ginsburg, 1999, p. 372). Hence, a qualitative research approach is the most appropriate for my project.

Texts

In this thesis, I treat theory and method as fundamentally linked. Methods used for social inquiry are shaped by theoretical stance. In Chapter Three, I employ textual analysis as the primary method and my understanding of the 'text' is informed by a poststructuralist theoretical position. Therefore, I approach textual analysis not as a method to discover the real meaning of a text, but to explore the meanings texts can produce. In particular, I examine the discourse that is produced and consider the implications this may have on service provision. As Jager and Maier (2009) argue, 'A discourse, with its recurring contents, symbols and strategies, leads to the emergence and solidification of "knowledge" and therefore has sustained effects. What is important is not the single text… but the constant repetition of statements' (p. 38). The recurring ideas that I identify introduce important messages with which readers (such as service providers, workers, consumers, etc.) must engage.

The findings presented in this thesis draw on two datasets: policy documents and in-depth interviews. In Chapter Four I analyse Australian alcohol and other drug policy documents for how they make the core concepts that constitute my field of study: alcohol and other drug use, addiction, treatment, marginalisation and youth. Whether they conceive addiction as an incurable disease, or as a curable substance use disorder, or some other entity, shapes service practices, and, as will be discussed in Chapters Five and Six, experiences. In Chapter Four, I examine two key alcohol and other drug policy documents for Australia and Victoria: the *National Drug Strategy 2010–15* (MCDS, 2011) and *Reducing the alcohol and drug toll: Victoria's Plan 2013–17* (SGV, 2012). In this analysis, I uncover tensions and inconsistencies between the documents, and examine how notions of alcohol and other drug use, addiction, treatment, marginalisation and youth are made in these important sites.

These policies offer insights into the ways that alcohol and other drug treatment goals are constructed, and how young people's alcohol and other drug use and addiction are conceived in Australia and specifically in Victoria, where this research project was conducted. In 1985, the first *National Drug Strategy* was published, as was the first Victorian Drug Strategy. Since then there have been multiple iterations of both the national and Victorian documents.

Although these strategies have remained mostly consistent over time, subtle changes can be identified. My analysis pays particular attention to the strategies that were at work when the participants in this research were in treatment. The *National Drug Strategy 2010–15* (MCDS, 2011) is 26 pages long, with an additional six pages dedicated to introducing and concluding the document. It is broken down into three sections, one on each of the Strategy's three 'pillars' – demand, supply and harm reduction. Each section is further divided into the following key objectives:

> **Demand reduction:** 1. Prevent uptake and delay onset of drug use, 2. Reduce use of drugs in the community, 3. Support people to recover from dependence and reconnect with the community, 4. Support efforts to promote social inclusion and resilient individuals, families and communities.
> **Supply reduction:** 1. Reduce the supply of illegal drugs (both current and emerging), 2. Control and manage the supply of alcohol, tobacco and other legal drugs.
> **Harm reduction:** 1. Reduce harms to community safety and amenity, 2. Reduce harm to families, 3. Reduce harm to individuals. (p. ii)

The Victorian policy, *Reducing the alcohol and drug toll: Victoria's Plan 2013–17* (SVG, 2012) is a larger document, 58 pages with an additional eight-pages introduction. Much of this document details 'Victoria's 15-point plan'. Chapter Four explores these 15 points in detail, but in brief, they cover alcohol; pharmaceutical drugs; illegal drugs; care, treatment and recovery; and leadership.

In my analysis, I coded the policies through the following process:

- initial coding of the two policies focused on the five themes central to this research: alcohol and other drug use, addiction, treatment, marginalisation and youth. Segments of data (i.e., words, sentences, paragraphs) relating to these themes were compiled in separate word documents;
- using an inductive constant comparison method (Huberman & Miles, 2002), my detailed reading of the coded material explored dominant accounts, inconsistencies and problematisations in each theme;
- the data from each theme across both policies was then compared for consistencies, inconsistencies and absences; and

- Throughout this process, I made notes to help draw out connections between and within the key themes.

The analysis focuses on how Australian and Victorian alcohol and other drug policy problematises particular practices and positions, and how these problematisations encourage particular definitions and responses.

Interviews

In addition to examining policy texts, I collected and analysed data through in-depth interviews. At a basic level, an interview is able to produce in-depth insights into perspectives on particular phenomena. As Marvasti (2004) notes, interviews 'provide detailed description and analysis of the quality, or the substance, of human experience' (pp. 10-11). Interview forms generate different information. While unstructured interviews allow participants to direct the conversation, semi-structured interviews allow the researcher to gently guide the conversation based on thematic areas relating to a study's key objectives. Semi-structured interviews permit 'a balance between some degree of consistency of topics, and flexibility in capturing or 'gathering' the elusive, the multiple or the indefinite in participants' stories' (Fraser & valentine, 2008, p. 30). In this project, I utilised semi-structured interviews to encourage the sharing of narratives and insights on the multiple realities of alcohol and other drug users in contact with services. The objectives of my project – the investigation of marginalised young alcohol and other drug users' understandings of consumption and addiction, and an exploration of the ways that they resist or accommodate discourses of addiction in their interaction with services – invited this approach. The data generated through the interview process can be understood as a 'resource for understanding participants' perspectives on drug use and addiction, as well as a means of 'exploring *how* these perspectives are generated' (emphasis in the original) (Rhodes & Coomber, 2010, p. 73).

However, as noted earlier, poststructuralist approaches to qualitative research hold that meanings and knowledge are generated through the research process. The world is not composed of known and unknown facts, nor is truth universal (Williams, 2005). As such, information gathered during interviews should not be seen as a straightforward window into reality. The interview is an interactive experience and a site of meaning making. Kuntz and Presnall (2012) advocate for 'An understanding of the interview as a wholly engaged encounter, a means for making accessible the multiple intersections of material contexts that

collude in productive formations of meaning' (p. 733). Thus, the poststructuralist approach encourages researchers to reject treating interview narratives and stories as rigid linear progressions arriving at a stable and static reality. Instead, we can recognise the way that they are shaped by 'an entanglement of desires, intensities, and flows' (Mazzei, 2013, p. 735), which sometimes conflict with one another, to produce meaning within that moment. This approach to gathering data can leave the researcher in an uncertain position. Addressing this uncertainty, Power (2004) suggests that 'Listening to understand a participant's logic of practice leads the analyst to look beyond, between, and underneath the participant's words, to understand the social space in which the participant is located and in which the interview took place' (p. 860). This encourages researchers to reject traditional notions of validity and testing the truth of accounts against each other, and instead contextualise accounts given and understand that meaning and knowledge is generated within that setting. Therefore, the data generated in these interviews must be understood within the context in which they were conducted, and it must be kept in mind that the words shared are not isolated from their environment. In doing so it will expose the range of accounts available to those who come into contact with alcohol and other drug services, while also giving a voice to participants which links to the poststructural ideals of action, advocacy, empowerment, and emancipation, as Marshall and Rossman (2010) discuss.

Using case studies

In the analysis of interview data presented in Chapters Five and Six, I use a case study technique to show how different service experiences shape approaches to alcohol and other drug use and treatment. Here, I explore what constitutes a case study approach to analysis and the benefits of such an approach to this project.

The case study method has attracted interest amongst social researchers. In particular, for qualitative researchers seeking to explore and expose meaning as it is made, shaped and evolves, the case study offers a unique way of gaining insight. As Tellis (1997) notes, 'case studies are multi-perspectival analyses. This means that the researcher considers not just the voice and perspective of the actors, but also of the relevant groups of actors and the interaction between them' (p. 2). As I discuss below, this approach resonates strongly with a poststructuralist approach and is well suited to an analysis that draws on a risk environment framework.

As observed previously, qualitative research seeks to explore the qualities or character of phenomena. Using case studies helps target the focus of such research towards in-depth understanding. According to Orum, Feagin, and Sjoberg (1991), A case study is … defined as an in-depth, multifaceted investigation, using qualitative research methods, of a single social phenomenon. The study is conducted in great detail and often relies on the use of several data sources (p. 2). They acknowledge that this definition is both intentionally broad and holds some ambiguity (ibid.). As with all qualitative research, case studies do not simply follow a prescribed formulaic approach, but utilise the methods of investigation most appropriate to the particular project, its field of study and participants.

I draw on Mol and Law's approach to cases. In their edited collection, *Complexities,* Annemarie Mol and John Law (2002) advocate three modes of analysing phenomena: lists, cases and walks. Drawing on this work, Fraser and Seear (2011) suggest that cases do the following:

1. They sensitise us to otherwise unrecognised events and situations;
2. Offer potentially 'translatable' ideas and insights;
3. In disrupting assumptions they can 'destabilise expectations';
4. They can be used as allegory, to speak indirectly about other things (p. 14).

Based on these ideas, in this project case studies are conducted at two levels. The services from which participants were recruited form the first level. The two services selected as case studies enabled exploration of differences, consistencies and tensions in service provision. Further, by selecting only two services, it facilitates in-depth analysis and contrasting between two dominant models. The services offer quite different approaches to alcohol and other alcohol and other drug treatment (although that is not to suggest that they are opposites, or that they have no commonalities). At the second case study level, several participant interviews will be discussed in detail. The analysis of these interviews aims to keep the stories 'whole' (Pienaar et al., 2015), without fragmenting the narratives. Focusing my analysis on select interviews aids a more in-depth exploration of the two central themes of this thesis: alcohol and other drug use and addiction. The narratives presented and analysed in this thesis were selected as representative of the common themes discussed by many of the participants. However, the stories presented in Chapters 5 and 6 also show the diversity of experiences and understandings of young people in treatment.

Mol and Law (2002) note that a, 'single text cannot be everywhere at once. It cannot do everything all at the same time nor tell all' (p. 6). These cases were selected and analysed with very specific parameters in mind. In presenting these data I make no claims that they are 'representative of something larger' (p. 15) nor do I make any attempt to 'begin at the beginning' or to 'commence from a point understood to be the origin of the ideas and issues [I] trace and analyse' (Fraser & Seear, 2011, p. 14). Instead, in selecting and presenting these cases, I follow Mol and Law (2002) who suggest we should:

> Take all cases as phenomena in their own right, each differing slightly in some (unexpected) way from all the others. Thus a case may still be instructive beyond its specific site and situation, and this tends to be why it is studied, but the lessons it holds always comes with the condition that, elsewhere, in other cases, what is similar and different is not to be taken for granted. It remains to be seen, to be experienced, to be investigated. (p. 15)

The two levels of case study analysis deployed in my research do not attempt to represent all treatment experiences, or all types of treatment available. Instead, they offer key insights to particular treatment experiences and perspectives on alcohol and other drug use and addiction. That said, these cases can be 'instructive beyond specific site and situation' in that they may draw attention to the diversity of treatment experiences, to show how some links between service provision and individual outlook arise, and highlight the need to continually explore this field.

My thematic analysis clearly demonstrated two key approaches to alcohol and other drug use and addiction that have clear links to treatment type and experience. These dominant accounts are further explored in later chapters, with subtle differences and unique points also being highlighted. The interviewees used as case studies in this research were selected specifically for their capacity to reflect dominant accounts, while also heeding the unique elements of individual experience.

The services

For the first level of the case study approach, I selected two services located in Melbourne, Victoria. They were chosen because their approaches differ significantly, along with the types of services and programs they provide. This section will briefly step out the key details of

each service. For confidentiality, these services are referred to as ‘Service A’ and ‘Service B’. Analyses of these services’ approaches to alcohol and other drug use and addiction are presented in Chapters Five and Six.

Service A was founded in 1986 as a society, by former alcohol and other drug users. It amalgamated with a similar organisation in 1995 and the service, as it is presently known, was established. Service A provides education, counselling, support and residential services to approximately 8,500 substance consumers and their ‘family members’ annually. It is funded by the Victorian DHHS, as well as government departments and a Trust. It incorporates the 12-step model (as used by Alcoholics Anonymous and Narcotics Anonymous) into its programs aimed at young people. This approach classifies addiction as an incurable disease characterised by an absence of volition (Addiction Centre, 2017; Al-Anon Family Group Headquarters, 1996). Service A (2017) is a ‘recovery’-oriented service that aims:

> To provide opportunities for individuals, families and communities affected by addiction and related problems to recover and achieve meaningful, satisfying and contributing lives. To provide models of practice for family support, consumer participation and peer based recovery support; and influence practice in the field of addiction and other related health domains. (Reproduced exactly from the service website)

The implications of this approach are explored extensively throughout Chapters Five and Six For now, it is necessary to note that this service emphasises ‘recovery’ as an outcome and that access is not limited to young people.

Service A offers three key program areas:

1. a residential program specifically for young people;
2. a support program for people affected by family members’ problematic substance use; and
3. an association which involves participating service users.

The participants in my research were recruited from the residential program, which accommodates people aged between 16 and 25 years. This service has 19 beds across seven residential houses. It services around 30 young people per year, who stay for eight months on average. Service A states that 80% of residents proceed to study and/or employment at the completion of the service program.

The concept of 'addiction' is highly significant to this service; a handbook it produces stipulates that '[Service A's] constitution requires that two thirds of the board members are people who have personally experienced addiction or have personal experience of a family member's addiction'; this is also referred to as being an 'expert by experience'. While job qualifications and experience are also considered in appointing board members, this stipulation concerning addiction experience facilitates a particular approach to alcohol and other drug service provision.

The other service analysed as a case study here is Service B. Service B is a not-for-profit agency which offers a range of service, programs and resources for young people aged 12–21 years (although in some instances this age bracket varies, such as in the Youth Support Service, which assists those aged 10–17 years who have had contact with the criminal justice system). Service B was established in 1998 'in direct response to increasing incidences of heroin overdose in hotspots throughout Victoria'. Despite this initial focus on heroin overdose, Service B now offers a range of supports for 'highly vulnerable and high-risk' young people experiencing alcohol and other drug problems, mental health issues and social disconnection. Service B is governed by a board of elected members and funded primarily through the DHHS, supplemented through systematic fundraising. Since its inception, Service B has assisted more than 20,000 young people and their families through a range of services including counselling, outreach, day programs, and withdrawal and rehabilitation facilities. These services are accessible from 12 sites across metropolitan and regional Victoria. The stated purpose of this service is 'to enable young people experiencing serious disadvantage to access the resources and support they require to lead healthy and fulfilling lives'. As an alcohol and other drug-focused service, its emphasis is on harm reduction and increasing access to resources that enable and promote health.

Service A and Service B offer a range of services and programs specifically for young people. They collectively offer counselling, detoxification, rehabilitation and day programs,

but not through all their services and sites. However, there are also fundamental differences between them. Service A has a 'recovery-oriented' approach that relies heavily on the concept of addiction. Its mission, which specifies its intent to help people with 'addiction and related problems to recover and achieve meaningful, satisfying and contributing lives' highlights the service's abstinence-based approach (discussed further in Chapters Five and Six). Service B, on the other hand, was developed in response to particular problematic substance use, and continues this approach, aiming to enable people to find the resources and support they require. As will be discussed in Chapter Five, Service B provides a more holistic approach to treatment, offering services through a wider range of programs and mediums. Service B does not adopt the same approach to addiction as Service A, but its emphasis on risk and harm is of interest to this project. Service B is harm reduction-oriented and aims to provide service support to vulnerable young people experiencing alcohol and other drug problems, mental health issues and social disconnection.

Participant recruitment

Between October 2015 and March 2016, I conducted in-depth qualitative interviews with young (18–24-year-old) marginalised alcohol and other drug users (some had in fact ceased all consumption as part of their service contact requirements) who were in contact with my two chosen alcohol and other drug services to discover the meanings they gave to alcohol and other drug use and addiction. This age bracket was chosen to capture differences according to developmental stages, and the dataset is varied by gender, ethnicity and other differences. The sample size of 19 was considered sufficient to meet the study objectives; as Marshal (1996) observes, 'an appropriate sample size for a qualitative study is one that adequately answers the research question. For simple questions or very detailed studies, this might be in single figures' (p. 522). Initial recruitment occurred through the services and snow sampling[5]. Here 'contact with alcohol and other drug services' means no less than either five counselling sessions or a week of detox or rehabilitation within the past six months. Often, participants had experienced a combination of service contact types. As will be explained later, the varied types of contact with services influenced understandings differently and produced different effects.

[5] Snowball sampling is 'a non-probability sampling method, often employed in field research, whereby each person interviewed may be asked to suggest additional people for interviewing' (Babbie, 2011, p. 208).

To recruit service users, I distributed flyers with the opening question 'Are you aged between 16 and 24 and currently attending an AOD service?' Many of the participants were referred directly by workers at the services who judged that their gender, age and treatment engagement made them eligible. I screened candidates further for eligibility researcher prior to recruitment, focusing on alcohol and other drug use and treatment experiences. Potential participants were also screened for their marginalisation status; I sought to interviews both regular and intermittent marginalised alcohol and other drug users. Following Cruwys et al. (2013), participants were defined as marginalised if they were experiencing one or more of the following: social stigmatisation (e.g., membership of a highly stigmatised group, being a welfare-reliant single parent, having a disability), early life disadvantage (e.g., parental unemployment, incomplete schooling), financial hardship (e.g., reliance on welfare, low income, high financial stress), poor health (e.g., chronic health problems, poor mental health, poor physical functioning) and social isolation (e.g., few social contacts, little social support, poor quality relationships).

As already noted, in-depth semi-structured interviewing was used to collect the data. The participants were recruited from one site for Service A and two sites for Service B. Participants were reimbursed with $40 gift vouchers for their time, which is consistent with Australian ethical research guidelines (National Health and Medical Research Council (NHMRC), 2007) and is common practice within alcohol and other drug research in Australia.

Interview content

Semi-structured interviews included open-ended questions to encourage the sharing of complex narratives. They included questions on the participant's current circumstances, ideas about alcohol and other drug use and addiction, goals they hoped to achieve from contact with the service, understandings of service objectives and relevance of these to their own situation. Participants were also asked what they thought 'addiction' means, and whether they considered themselves 'addicted'. Interviews were digitally recorded and professionally transcribed.

Interview analysis

Interview data was analysed via an inductive process of identifying analytical themes and categories as they emerged (Pope, Ziebland, & Mays, 2000). Recruitment of participants

from two services allowed me to use their perspectives to compare and contrast service experiences. Informed by literature on addiction and risk environments, the first step involved assigning thematic codes (e.g., notions of addiction, social and economic circumstances, understandings of risk, harm and responsibility) to segments of the data (words, phrases, paragraphs). The method of constant comparison, where each item is checked and compared with the rest of the data (Moore & Fraser, 2013; Pope et al., 2000), was used to establish and refine the analytical categories. Data was examined for how types and levels of environmental influence shape experiences and narratives, and for the ways in which consumer narratives both challenge and reproduce wider discourses of addiction. Information on the macro environment, including relevant policy and the alcohol and other drug services' approach to treatment, complements the analysis of the consumers' interview data as it seeks to illuminate consistencies and discrepancies in approaches and understandings. I coded and analysed the interview transcripts in the following way: using NVivo[6] (QSR International, Melbourne), a list of preliminary codes was developed based on themes that emerged from the data, as well as my knowledge of key debates and past research. The participants' narratives presented in Chapters 5 and 6 are representative of the key approaches and themes identified when analysing all the interview data. Yet they also provide insight into the diversity of experiences of young people in treatment.

Ethical issues

All potential participants were given a printed plain language statement regarding the purposes and procedures of the study and a verbal explanation of the key points relevant to their involvement and their rights as a participant. They were asked to explain in their own words the meaning of the information I provided in order to confirm that they had the mental maturity and comprehension skills required for them to provide informed consent. Informed consent was given verbally, audio-recorded and subsequently transcribed, and as per the *Australian Code for the Responsible Conduct of Research* (NHMRC, 2007), participants were informed that they could withdraw their consent at any time, whereby the information they provided would be securely destroyed.

[6] NVivo is a computer software designed for qualitative data analysis by QSR International. It was suitable to use in this project as it assists in the in-depth analysis of rich text-based information. It is popularly used in the field of social research.

Respect is fundamental to ensuring the protection of participants from harm and distress. Given the sensitive nature of the information I collected, I endeavoured to be sensitive to the participants' needs. Contact details for support and counselling services were listed on the plain language statement in case participation in the project resulted in any distress. The expected benefits, including the development of insights into marginalised young alcohol and other drug users' experiences with services, were deemed to outweigh the small potential for unexpected harms incurred by participation in the research.

This project required participants to have current or recent contact with an alcohol and other drug service. Although the research was not 'specifically intended to discover illegal behaviour' (NHMRC, 2007, p. 60) it was likely to do so; this, and other portions of the information obtained through the interviews, was sensitive data and required a high level of privacy and confidentiality. Interviews in public were conducted in places that ensured privacy and anonymity. Although the material was treated as confidential, legal orders can compel the disclosure of confidential information and thus the participants were informed that this could occur (ibid.). All participants were allocated pseudonyms for use in the research. Findings published in this thesis comply with the privacy and confidentiality terms stipulated by the Human Research Ethics Committee for this project.

Conclusions

In this chapter I discussed my theoretical orientation and methodological approach together, to demonstrate their interconnectedness. The theoretical orientation of research shapes data collection and methods of analysis. Indeed theory and method are inherently connected and rely on each other. From the beginning, in this chapter I explored a way of thinking and learning about marginalised young people's alcohol and other drug use and notions of addiction. Beginning with an introduction to poststructuralism, the chapter highlights that the knowledge generated in interviews is co-produced and meaning emerges through the production of the interview itself. A poststructuralist account disputes Enlightenment assumptions of a single reality and essential truth, and the idea that information gathered during interviews can be seen as a straightforward window into reality. Similarly, perceptions of and engagement with the notion of risk cannot be treated simplistically as an exercise in harm negotiation. These thoughts provide a basis for the use of a risk environment framework, which can aid in analysing the multiple discourses that help to shape and characterise harms and risks attributed to alcohol and other drug users. Similarly, narratives

concerning concepts of addiction can be employed in semi-structured interviews in order to investigate similarities and differences between service approaches to alcohol and other drug use and addiction, and the lived experiences of those whom they seek to 'treat'. Most importantly, by presenting my theoretical orientation and methodological approach together in this thesis, I aim to accommodate the poststructuralist observation that meanings are generated through the research process. While analysis of data collected in qualitative semi-structured interviews is able to produce in-depth understandings of participants' perspectives and experiences, it must also be noted that the researcher and the process of the research itself actively shape this in-depth understanding.

These key insights are taken forward in my use of case studies. Building on the merits of qualitative research, using case studies as a means of presenting analysis aids in targeting my research towards a highly specific understanding on young people's perspectives of alcohol and other drug use and addiction, as shaped by their treatment experiences. Particularly, case studies (as will be demonstrated in Chapters Five and Six) help to expose how the two starkly different service approaches impact on these experiences and understandings.

In the final elements of this chapter I outlined the conduct of the research itself. Who were the participants who engaged in this study, what methods of analysis were used, and what ethical issues were considered? These details underpin the findings of this research. The participants who engaged in this study did so with minimal tangible reward. The participants ranged from 18 to 24 years of age and were experiencing a range of hardships. In addition, most often they cited multiple service engagements as part of their treatment trajectories. Therefore, the later parts of this chapter speak not only of the rigorous processes that formed part of the data collection and subsequent analysis, but point towards the ever-increasing need for social researchers to be mindful of the generosity of their participants, especially those who are marginalised, and the impact their research could have on the wellbeing and futures of those on whom they have relied.

Chapter Four: Making youth alcohol and other drug use in policy

In this chapter I analyse policies that govern and influence the treatment sector in Australia and Victoria. My systematic analysis explores how alcohol and other drug use, addiction, treatment, marginalisation and youth are framed. To begin, I look at the national approach to these themes articulated in a key policy document. Next, I apply the same analysis to the corresponding state-level policy. I analyse dominant approaches to the concept of addiction, which can be loosely divided into two broad approaches: perceptions of addiction as an enduring problem and perceptions of it as a temporary problem. Within these two overarching ideas, several models of addiction circulate, including an approach to addiction based on the DSM-5 substance use disorder model and a more historically situated disease concept. Throughout this chapter, I explore how alcohol and other drug problems and addiction are articulated and produced in policy discourse.

In conducting this analysis, I do not dispute experiences of short and long-term harms in the context of alcohol and other drug use. However, I do suggest that a more nuanced approach to these harms offers better insight to how harms are shaped, attributed and understood. As argued below, understanding the construction of addiction allows a clearer view of its operations and effects than does understanding it simply as a medical diagnosis. The insights I develop will provide a necessary basis for understanding how the services I analyse in the following chapters shape their approaches and programs, and in turn, how participating young people are invited to understand themselves.

Since 1985, Australia's alcohol and other drug policies have remained remarkably stable and consistent (Ritter et. al., 2011). Alcohol and other drug use occurs throughout Australian society, but alcohol and other drug problems are more frequently attributed to those who hold a marginalised status. Harm minimisation and evidence-based approaches to treatment are central tenets of Australian policy and as such attract academic interest. According to Ritter, Lancaster, Grech, and Reuter (2011), Australia's harm minimisation framework is well developed and more effective than approaches in many other countries. Harm minimisation is the over-arching approach adopted in Australia and comprises three 'pillars': demand reduction, supply reduction and harm reduction (MCDS, 2011). As such, policy in Australia situates drug use in both the criminal and health spheres (Ritter et. al., 2011). As Ritter et al. (2011) note, Australian drug policy 'still places great emphasis on law enforcement but,

compared to other countries, it appears that Australia has better balanced law enforcement with treatment measures' (p. 46).

The version of the *National Drug Strategy 2010–15* (MCDS, 2011) analysed here is much the same as past versions, having adopted the same overarching approach of harm minimisation since 1985. Three versions preceded the one I analyse here. In all cases, as Ritter et al. (2011) note, the 'five basic features … of the "Australian approach" are included, i.e. harm minimisation; a comprehensive approach; partnerships; a balanced approach; and a commitment to evidence based policy' (p. 7). For my purposes, the first observation to make about the *Strategy* is that the notion of harm is taken up in the document as an obvious consequence of alcohol and other drug use. It states, 'the harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco and other drugs [are] well known' (p. 2). Moreover, particular 'disadvantaged populations' and 'age/stage of life' groups (such as adolescence) are identified as being at greater risk of harms (p. 3) and ready access to treatment is stipulated as a necessity for people who experience 'dependence' (p. 11). Accessible treatment is presented as a supportive tool that enables people to rebuild their lives and reconnect with their communities when they experience problems (ibid.). In this chapter I build on recent scholarship to explore how 'problems' are actually made and constituted in the policies that aim to address them. This will demonstrate how the policies work to produce the phenomena they aim to address, and how Australian national and state policy approaches to alcohol and other drug use, addiction, treatment, marginalisation and youth constitute particular realities.

Is policy making 'addiction'?

In their 2013 analysis of Victorian treatment system policy, Moore and Fraser observe that 'rather than merely treating pre-existing addicts… the system works to produce "addicts" as an effect of policy' (p. 916). Indeed, the ways alcohol and other drug problems are fashioned in policy documents informs many of the models and modes that treatment services utilise to diagnose addiction or 'dependence' in everyday practice. Two of the three pillars of the *Strategy* especially value consumption reduction as a priority. Both demand reduction ('actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs') (MCDS, 2011, p. 2) and supply reduction ('actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs') (p. 2) emphasise this point. Under the demand reduction pillar, objective three aims to 'support people to recover from

dependence and reconnect with the community' (p. 11), and further identifies marginalisation as a common consequence of drug use (p. 12). Suggesting that 'dependent' people need to 'reconnect' both recognises and reinforces their marginalisation, simultaneously erasing questions about the social inequalities that directly shape marginalisation. Additionally, this objective frames people who seek alcohol and other drug treatment as 'dependent', thereby imposing a diagnosis prior to treatment engagement, as will be demonstrated in the analysis to follow. These preliminary arguments demonstrate the basis for the analysis to follow: by identifying and mobilising addiction, dependence and drug-related harm, we produce these concepts in practice.

National policy

As I have noted, the *National Drug Strategy 2010-15* (MCDS, 2011) is Australia's key document guiding national and state-level responses to alcohol and other drug use and related policies. In this section I analyse the *Strategy* in detail, addressing five themes of relevance to my project: alcohol and other drug use, addiction, treatment, marginalisation and youth. Overall, I argue that the *Strategy* uses a combination of supported claims and disputable arguments to present alcohol and other drug use as intrinsically harmful and to frame young people as underdeveloped bodies in need of increased surveillance and regulation. These approaches serve to define and shape popular and professional (e.g., service) approaches to alcohol and other drug use and help to constitute the risk environments in which young people operate.

What is wrong with alcohol and other drug use?

Within the *Strategy*, alcohol and other drug use is constructed as unsafe and unhealthy, linked to a diverse range of physical, mental and social harms. These harms are both general and specific. For instance, alcohol and other drugs are presented as inherently harmful, yet specific groups (such as young people) are identified as being especially vulnerable to their harms. Although not directly stated, the policy implies that alcohol and other drugs produce a risk of dependence. The problem, therefore, lies both with the substances and with the people who use them.

The construction of alcohol and other drugs as unsafe and unhealthy begins where the aims and mission of the policy are set out. The *Strategy*, we read, sets out to 'build safe and healthy communities' (MCDS, 2011, p. 1); 'resilient communities' that 'promote safe and

healthy lifestyles' (p. 13). It goes on to list an extensive range of harms, presenting alcohol and other drug use as a risk factor for harm. For example, in discussing alcohol, it notes that:

> Short episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease and brain damage, and contributes to family breakdown and broader social dysfunction. (p. 2).

Illicit drug use is represented as responsible for similar 'dangerous health impacts'. Also included is the proposition that illicit drugs are a 'major activity and income source for organised crime groups' (2011, p. 2), and, as such, significantly contribute to crime.

As noted, specific groups are identified as particularly vulnerable to harm. The *Strategy* identifies particular 'age and stage of life' transitions (MCDS, 2011, p. 5) linked to increased risk of alcohol and other drug-related harms. Young people are identified as being especially vulnerable to these harms, as can be seen in the following statement: 'Young people are more at risk of motor vehicle accidents, injuries, accidental death and suicide whilst under the influence of alcohol and drugs. They are also highly susceptible to being victims of crime' (p. 6).

The approach to young people as at greater risk of harm from alcohol and other drugs is reiterated throughout the document (MCDS, 2011) and is discussed in greater detail below. It is important to note that those identified to be at greater risk of harm include groups other than young people: older people (aged 65 or above or retiring from the workforce); the disadvantaged and socially isolated; Aboriginal and Torres Strait Islander people; those experiencing mental illness; people living in regional or remote areas; culturally and linguistically diverse people; gay, lesbian, bisexual, transgender or intersex people; and former prisoners (pp. 5-7).

While the *Strategy* considers risk in terms of groups, it represents alcohol and other drug use as motivated by individual deficits – weakness, lack of coping skills or trauma. For instance, when treating dependence, the *Strategy* states providers should 'help the individual access the internal resources they need (such as resilience, coping skills and physical health)' (MCDS, 2011, p. 11). In doing so, these objectives work to create an environment in which people

experiencing alcohol and other drug related problems are attributed with the stigma of lacking these resources (irrespective of whether they are or not). Whilst the *Strategy* does acknowledge social reasons for alcohol and other drug use and pleasure, these reasons are quickly discounted by the focus on more negative motivators: 'People use drugs for a range of reasons including as an integral part of social behaviour, to experiment, because of peer pressure, to escape or cope with stress or difficult life situations or to intensify feelings and behaviours' (p. 9). Such framings reinforce assumptions about the role played by pathology and trauma in alcohol and other drug use (Moore et al., 2015).

To sum up the *Strategy's* approach to the nature and role of alcohol and other drug use, it relies on the idea that much use, especially heavy use, is motivated by individual flaws and a lack of internal coping resources. At the same time, substances are presented as the cause of dependence and other harms, and specific groups, such as young people, are identified as being at heightened risk of harm. Despite some recognition that people can use alcohol and other drugs for pleasurable purposes, this is overshadowed by the *Strategy's* frequent connections between alcohol and other drug use, flawed or vulnerable consumers and physical, mental and social harms.

Framing 'addiction'

While the *Strategy* does raise issues of addiction, this term is not used. Instead, it uses terms such as dependence, misuse, problematic drug use, alcoholism and disorder. Yet, despite their frequent use – at times interchangeably – these terms are never clearly defined. The absence of a definition signifies a lack of clarity in how addiction is conceived throughout the document. Given addiction concepts do not enjoy much clarity in health, scientific and other contexts, it is unsurprising that the *Strategy* echoes this instability. Indeed, it further serves to illuminate the 'contextual and sociologically contingent nature of addiction' (Granfield & Reinarman, 2014, p. ix).

Although the *Strategy* connects alcohol and other drug use to various diseases (such as liver, respiratory and heart disease and cancer) (MCDS, 2011, p. 2), 'dependence' is more often employed in a way that suggests it is conceived as a social problem. People with dependence are presented as disenfranchised, ostracised from the community, leading meaningless lives and subservient to alcohol and other drugs. For example, under Objective 3 of the Demand Pillar: 'Support people to recover from dependence and reconnect with the community', we

read: ‘Recovering from drug dependence can be a long-term process in which individuals need support and empowerment to achieve independence, a healthy self-esteem and a meaningful life in the community’ (p. 11). Here, individuals with dependence are characterised as damaged, in a state of trauma, and lacking the internal resources to help themselves live healthy lives. The *Strategy* goes on to say that ‘Treatment service providers can help individuals recover from drug dependence [and] help the individual access the internal resources they need (such as resilience, coping skills and physical health)’ (p. 11).

The *Strategy* also states that dependence can result from damage done to the brain through consumption: ‘Alcohol-related damage to the brain can be responsible for memory problems, an inability to learn, problems with verbal skills, alcohol dependence and depression’ (MCDS, 2011, p. 5). Here, dependence is framed as a problem that results from a combination of internal weakness, an inability to make healthy life choices, and repetitive use of alcohol and other drugs that damages the brain. The emphasis on the brain as a key site for addiction is established in neuroscientific discourses (Weinberg, 2002).

Most commonly throughout the document, people experiencing dependence are depicted as unstable and socially marginalised. Treatment (as discussed further below), is designed to target alcohol and other drug use and the personal flaws of the consumer. The Strategy states, ‘for dependent users, reducing and/or ceasing the use of drugs can help them to lead more stable, healthy and productive lives’ (MCDS, 2011, p. 10). This suggests that people conceived as dependent are weak and lack the coping skills to be able to make the right life choices. Elsewhere it also implies that people who ‘misuse’ drugs are negligent, and fail to fulfil their responsibilities towards their children: ‘Children living in households where parents misuse drugs are more likely to develop behavioural and emotional problems, tend to perform more poorly in school and are more likely to be the victims of child maltreatment’ (p. 2). Such statements made in the *Strategy* imply that parental misuse alone leads to certain harm to children. Notably, they go unreferenced.

Where misuse and dependence are conceptualised as hindering people who have low self-esteem and live meaningless lives without autonomy, treatment is characterised as a form of liberation (MCDS, 2011). According to Moore et al. (2015), the *Strategy* singles out alcohol and other drugs use as ‘the primary issue to be addressed’ (p. 422) in contexts where affected individuals face a range of challenges and problems. However, there is some recognition in

the document of the importance of external services and support. Listed under the Demand Pillar (MCDS, 2011) are requirements for external services 'such as stable accommodation, education, vocational and employment support and social connections' (p. 11). These consistently position dependent users as socially isolated and impoverished. While there is no doubt a need for better resourcing of marginalised people and those facing multiple challenges, many people potentially classified as dependent users are well integrated, well-resourced members of the community. This blanket representation of dependent users further stigmatises the very people it argues need to be better integrated. Furthermore, it tasks treatment services with helping provide and enable these external services, which raises further issues for those who experience barriers to treatment.

In summary, the *Strategy's* concept of addiction, most commonly referred to as 'dependence', is unstable and, at times, unclear. Dependence is used to describe an effect of alcohol and other drug use, and at the same time it marks those consumers deemed most at risk. More than just being at risk, this creates a risk environment where individual resources, resilience and volition are not acknowledged. Dependent consumers are depicted as lacking individual resources, and unable to make the right life choices, thus reinforcing their abnormality and non-conformity. Within this framework, drugs and individuals are the key focus for change, while larger questions about social arrangements, resourcing and stigma are neglected.

What should treatment achieve?

Alcohol and other drug treatment receives significant attention in the *Strategy*. Some of this attention is directed to priorities and future directions, including developing workforce skills and capacity, and performance management (MCDS, 2011). Also discussed are different types of treatment: evidence-based early intervention programs, diversion, counselling, rehabilitation, relapse prevention, aftercare, detoxification and pharmacological and psychological approaches (pp. 4, 9). Despite this extensive list, preventive strategies are identified as more cost effective and brief interventions are framed as particularly effective in identifying 'current or potential problems with drug use and motivat[ing] those at risk to change their behaviour' (p. 10). In emphasising the benefits of early brief interventions, the *Strategy* notes their ability to refer people to specialised services 'before harms and long-term dependence occur' (p. 11). In this way the *Strategy* suggests that even people who have not experienced harm can benefit from service engagement.

More specifically however, the *Strategy* advocates treatment as a means of enabling people to recover from dependence. Unsurprisingly, given the characteristics the *Strategy* ascribes to dependent users (as discussed above), treatment is presented as facilitating individual change. These changes target consumption patterns, reducing or ceasing use (MCDS, 2011, pp. 9-10), and altering individual behaviour and decision-making processes (pp. 10-11). Some of these changes, the *Strategy* proposes, need to occur even before treatment commences: 'For many individuals this [awareness of incurred harms and motivation to seek and engage with treatment] requires a change of perspective and self-acknowledgement of a drug-related problem before there is a willingness to enter treatment' (p. 18).

Two important points emerge here. Firstly, 'drug-related problems' require diagnosis and acknowledgement before treatment can commence. Secondly, the effectiveness of treatment is strongly related to a change of perspective and self-acknowledgement of individual 'drug-related problems'. Treatment is also presented as a process of repairing the damaged lives of those who are disconnected from the community: 'In instances of dependence, it is important for people to have access to effective and affordable treatment services and where needed, support for rebuilding their lives and reconnecting with the community' (MCDS, 2011, p. 11). 'Rebuilding' and 'reconnecting' suggest that damaged lives and social ostracisation are taken-for-granted products of dependence. Instead, the relationship between dependence and marginalisation is far more complex. It also suggests that treatment is separate from what is needed to reconnect with the community.

The *Strategy* portrays people in treatment as unstable and requiring help in many aspects of their lives. It advocates strong partnerships and integrated service approaches to help people with 'mental health issues' (MCDS, 2011, pp. 3, 5) and 'complex needs' (p. 7), claiming that this will help people 'stabilise their lives, reintegrate with the community and recover from alcohol and other drug-related problems' (p. 7). Allusions to instability, social ostracisation, and alcohol and other drug-related problems are common in this field, and may be well-meaning, yet they serve to pigeonhole people who seek treatment as (at least to some degree) marginalised. Also of concern is the lack of attention paid to the 'normal' use of alcohol and other drugs, including their social and pleasurable use of alcohol and other drugs. Instead, the *Strategy* depicts people who use alcohol and other drugs as likely to suffer harm and inflict it on those around them. Here, families (p. 17), service workers and emergency response

personnel (p. 20) are cited as requiring additional support as a result of the trauma they experience when interacting with substance consumers. The *Strategy* also prioritises partnerships with law enforcement and the health sector (p. 1); this presents alcohol and other drug consumers as sitting in a fragile place between criminality and poor health.

Although preventive strategies are presented as financially preferable and brief interventions as particularly effective, many of the services listed do not fall into these categories. Priorities for developing partnerships between alcohol and other drug, mental health and law enforcement sectors serve to frame clients of alcohol and other drug treatment as mentally unstable and predisposed to criminal activity.

In general, the *Strategy* offers confident support for treatment. It claims that 'far more is [now] known about what works in the treatment of alcohol and other drug dependence' (MCDS, 2011, p. 4) and that 'evidence supports the effectiveness of a range of appropriately targeted treatment approaches' (p. 11). However, the evidence supporting these statements is not cited. It also outlines current treatment models and future directions. Treatment, the *Strategy* suggests, is designed to enable individual changes, yet the Strategy ignores the obstacles people face in doing so. For young people, who are the focus of my research, these policies create a risk environment. In these policies, young people are portrayed as exceptionally vulnerable to harm and unable to make the 'right' life choices. These highly prescriptive ideas about treatment and youth fail to account for any purposeful or pleasurable alcohol and other drug use.

What makes marginalisation?

As noted at the outset, marginalisation is a topic of particular interest to this thesis. In the *Strategy*, this term is not used. Instead, the terms social disadvantage (MCDS, 2011, p. 2), disadvantaged population (pp. 2-3), and disadvantage and social isolation (p. 6) are used. These terms refer to people experiencing homelessness, poverty, family breakdown and illicit drug use (p. 6). Several groups are classified as being at risk of experiencing disadvantage and isolation: Aboriginal and Torres Strait Islanders (pp. 2, 6, 7), people living in regional and remote areas, people with co-occurring mental illnesses, people in prison (p. 6), culturally and linguistically diverse populations, and people with multiple and complex needs (p. 7). People experiencing isolation and disadvantage are presented as different from socially included and resilient people; in particular, disadvantaged people are characterised by an

absence of stability in their lives (p. 11). People who are socially ostracised and disadvantaged are also positioned as more likely to experience harm from drug use (pp. 2, 8, 18). For example, in its discussion of demand reduction, the *Strategy* targets promoting social inclusion and resilience:

> Socially inclusive communities and resilient individuals and families are less likely to engage in harmful drug use. Resilient individuals can adapt to changes and negative events more easily and reduce the impacts that stressors have on their lives—and are less likely to use drugs (p. 13).

Ironically, change is framed here as something that people who lack resilience are both poorly equipped to cope with and yet require if they are to improve their lives and develop personal resilience.

Connections are continually drawn between social isolation, disadvantage and alcohol and other drug use. Indeed, the *Strategy* presents the relationship as a reciprocal one in which each causes and confirms the other. Socially isolated and disadvantaged populations have an increased risk of incurring alcohol and other drug-related harm (MCDS, 2011, pp. 2, 9, 18), while alcohol and other drugs can contribute to and reinforce social isolation and disadvantage (pp. 2, 12). Moreover, according to the *Strategy*, preventive factors such as having a job, a stable family life, and stable housing help to guard against experiencing problematic alcohol and other drug use (2011, pp. 6, 13). Under the heading 'Disadvantage and social isolation', the *Strategy* states that socio-economic status is connected to an array of alcohol and other drug-related harms primarily concerned with poor health. This suggests that people who experience disadvantage and poor socio-economic status are less concerned with health priorities. Overall, disadvantaged groups are characterised throughout the *Strategy* by an absence of wellness, yet little attention is paid to the complex political and social dynamics that produce this effect. Experiences of marginalisation have a strong influence on the social environments afforded to the people who engage in them, and in turn affect the actual and perceived risks that marginalised people are said to face.

As explored above, marginalised people are characterised in the Strategy in particular and distinct ways. Disadvantage and social isolation are described as things individuals

experience, in the form of homelessness, unemployment and poverty. However, they are also described as things individuals embody: they are less resilient, less concerned with health priorities. Populations identified as disadvantaged and socially isolated are thus targeted as sites for change. This is to some extent understandable, but may also serve to further problematise people experiencing these circumstances, and place the blame for harms on them. The 'protective factors' cited that guard against marginalisation (such as employment, family and housing) serve to define those who experience disadvantage by comparison, and also rely upon apparently unexamined societal values and ideals.

What characteristics define youth?

The last thematic area I analyse in the *National Drug Strategy* is that of 'youth'. 'Young people' (sometimes referred to as adolescents (MCDS, 2011, pp. 5-6) or teenagers (p. 6)) are discussed often in the *Strategy*. The *Strategy* suggests that young people are characterised by impressionability and propensity to take risks. How does this propensity arise? Families are identified as a key influence for young people's risk taking, and young people are repeatedly described as more likely to engage in alcohol and other drug use, and to smoke tobacco if their parents did/do (pp. 2, 18). However, irrespective of family behaviour, young people are said to be *predisposed* to taking risks. Thus we read that 'the adolescent drive to take risks and the need for coping mechanisms during adolescence can be major influences on the uptake of illegal drugs by teenagers' (p. 6). This reliance on debatable 'drive theory' raises questions. What makes young people 'predisposed' to taking risks? What underlying assumptions about young people's behaviour are at work here and what makes them behave in particular ways? Farrugia (2014) observes similar characterisations of youth drug use in his analysis of Australian drug education. One dominant account, Farrugia (2014) argues, is that 'young drug users are constituted [in drug education material] as distressed individuals who turn to drugs as a way of escaping from the difficulties of life' (p. 663). Dominant discourses in drug education often construct young people's drug use as a 'band-aid' for other 'problems' in their lives (p. 666). This construct is present in the *Strategy*. It connects family conflict and poor parent-child relationships to young people's alcohol and other drug consumption (MCDS, 2011), and portrays it as a coping mechanism for trauma experienced in other aspects of their lives. Here, the family is presented as both able to prevent young people's use (through restricting access) and to stimulate their use (in instances of supply, or conflict and ensuing trauma). Young people rely on supportive family networks to help them 'develop the skills to manage the next stage of life' (p. 13). They are unable to make the right

life choices without support, and families are held responsible as providers for their complex needs.

Throughout the *Strategy*, young people are framed as particularly vulnerable to risk and harm. They are presented as especially vulnerable to motor vehicle accidents, injuries, accidental death and suicide when consuming alcohol and other drugs (MCDS, 2011, p. 6). Evidence to support these claims is mostly absent. Importantly, while the *Strategy* comments on youth vulnerability, it does so selectively. Notwithstanding that young men are more likely to consume alcohol and other drugs (especially alcohol) (alcoholthinkagain, 2014) and experience higher rates of related harm (Australian Drug Foundation, 2013), they have significantly lower prevalence of psychosocial complexities (Bruun, 2015) and mental health concerns (Australian Bureau of Statistics, 2013) than women. Yet despite these findings, the *Strategy* only selectively considers sex and gender. As Moore et al. (2015) note, the most prominent gendered concern in the *Strategy* centres on maternal alcohol and other drug use:

> This willingness to repeatedly specify gender in relation to maternal alcohol and other drug use, while ignoring the substantial harm associated with the use of alcohol and other drugs by fathers and other men, seems at odds with the document's apparent reluctance to raise the issue of gender in other sections. (pp. 425-426)

Despite youth being depicted in the *Strategy* as vulnerable to increased risk and harm, the notion of youth goes ungendered even though we know the harms vary starkly by gender.

Citing 'emerging health evidence', the *Strategy* advocates delaying the introduction of alcohol to young people. In doing so, it reinforces the idea that young people are at increased risk of alcohol-related harm, offering brain development as an explanation for this susceptibility: 'Drinking alcohol in adolescence can be harmful to young people's physical and psychosocial development. Alcohol-related damage to the brain can be responsible for memory problems, an inability to learn, problems with verbal skills, alcohol dependence and depression' (MCDS, 2011, p. 5).

Connections between alcohol and other drug use, addiction and the brain have long attracted academic interest. In a recent article, Farrugia and Fraser (2017) explore how neuroscience is shaping logics and assumptions about addiction and youth. Reliance on the brain as an

explanation for addiction, and as the locus of alcohol and other drug harms, serves to separate people's consumption practices from the political, economic and social environments – we might say risk environments (Rhodes, 2005, 2009) – in which they occur.

In sum, the *Strategy* presents young people as an ungendered and undifferentiated 'group' predisposed to risk taking, and especially vulnerable to alcohol and other drug-related harm. Also of note is how the *Strategy* depicts the role of the family. Positioned as partially responsible for young people's use, it is expected to fulfil particular roles in their lives as custodians of those at risk. In response to youth consumption, the *Strategy* recommends restricting young people's access to alcohol and tobacco, and encourages parents and siblings not to supply to young people (MCDS, 2011, pp. 15-17). Young people, this suggests, are unable or unwilling to manage their consumption and require other means of control (such as age restrictions and adult interventions). It also suggests that strategies of denial and withholding are effective for those young people likely to take an interest in alcohol and other drugs. Importantly, these characteristics and explanations link back to conceptualisations of young people as underdeveloped. In particular, neuroscientific discourses of brain development appear to be shaping the *Strategy* and its approach to young people. In contrast to the *Strategy's* approach to youth consumption, Mayock (2005) suggests that:

> Young people "script" risk as they gain experience in the world… [and] they learn by doing and script elaborations are precisely what such learning is about. Correspondingly, they alter, modify, and innovate scripts to accommodate new drugs, novel use settings, and emergent events, as well as changing perceptions of safety and harm. (p. 362)

From this point of view, youth alcohol and other drug consumption could be better understood as a normal process during a period of life when young people learn to manage risks that have previously been managed by others (Farrugia & Fraser, 2017).

State policy

In the text above, I analysed Australia's primary alcohol and other drug policy for how it works to constitute and produce ideas concerning five key themes. Presented here is a similar analysis conducted on the key Victorian policy. Once again, the five themes (alcohol and other drug use, addiction, treatment, marginalisation and youth) are taken up and explored. In

addition, in the analysis below I aim to draw out both consistencies and tensions between the two policies.

Likening alcohol and other drug use to road fatalities, the Victorian Government developed *Reducing the alcohol and drug toll: Victoria's plan 2013–2017* (SGV, 2012). This document 'sets out how the Victorian Government will work together with the whole community to bring down the alcohol and drug toll' (p. v). Drawing on a range of sources including statistical reports, government reports, two scholarly articles and submissions from community agencies and stakeholders (pp. 50, 57-58), the *Plan* addresses the use of alcohol, pharmaceutical drugs and illegal drugs. In this section, I examine how the *Plan* draws on preconceived notions to problematise alcohol and other drug use, addiction, treatment, marginalisation and youth. As with my analysis of the *Strategy,* I utilise these areas of concern to divide my discussion into five sections.

Firstly, however, I provide a brief description of the *Plan*. This policy details Victoria's approach to reducing harms related to alcohol and other drug use through an agenda 'to do better – legal and regulatory reform, service delivery, cultural change and research' (SGV, 2012, p. v). To achieve this, it presents a '15-point plan' that addresses alcohol; pharmaceutical drugs; illegal drugs; care, treatment and recovery; and leadership. Under these headings, 15 sub-headings form the 'points' of the plan. These describe specific areas for action, for instance: 'reducing alcohol-related violence', 'effective liquor regulation'; 'better controls and evidence on misused pharmaceutical drugs'; 'better referral of drug users to treatment', 'improved harm-reduction services and targeted prevention'; 'community-based action on social factors driving substance misuse' and 'promoting successful recovery and reducing stigma in the community' (pp.3-5. Of note here is the greater attention paid to addressing alcohol use (five areas of action) than pharmaceutical drugs (two areas of action) and illegal drugs (three areas of action).

What is wrong with alcohol and other drug use?

In the *Plan*, alcohol and other drugs – categorised as pharmaceutical drugs and illegal drugs – are constructed as either inherently harmful in the case of illegal drugs or as harmful if 'misused' in the case of alcohol and pharmaceutical drugs. Particular groups (such as young people who are described as prone to 'excessive' drinking) are positioned as especially vulnerable to these harms or misuse. Throughout the *Plan*, drug users are constructed as

unsafe, unhealthy, and experiencing multiple concerns: 'Victoria's approach aims to encourage drug users to get off the drugs and to tackle their health and other concerns' (SGV, 2012, p. 34). While the *Strategy* employs the term 'alcohol and other drugs', thereby constructing alcohol as another type of drug, the *Plan* refers to 'alcohol and drugs'. This constructs alcohol and drugs as two distinct categories, reflecting a now generally discredited tendency to consider alcohol a harmless social substance in contrast to more sinister illicit drugs. Further, unlike the *Strategy*, the *Plan* also distinguishes categories of drugs (i.e., pharmaceutical or illegal). By separating 'drugs' into types, the *Plan* works to produce some types of use (such as monitored pharmaceutical use for medicinal purposes) as safe and legitimate. However, if we understand some types of use as safe and legitimate, then use that does not adhere to these principles must be, by comparison, unsafe and illegitimate. This distinction, and its additional separation from 'non-drug use' such as drinking alcohol, reinforces and perpetuates the pharmacologically baseless stigmatisation of illegal drugs as uniquely harmful.

The five points in the *Plan* concerned with alcohol target its 'misuse', potential harm and related anti-social behaviour. The *Plan* does acknowledge the 'many benefits – vibrant, liveable cities and regions, prosperous businesses, and good times with friends' (SGV, 2012, p. 14) – of alcohol use. However, it warns against harmful, or 'excessive' or 'risky' drinking. 'Risky' drinking is presented as the opposite of drinking that stays within 'healthy limits', and the *Plan* claims that 'one in ten Victorians drinks more than [sic] healthy limits at least weekly' (p. 10). What are the healthy limits? The *Australian Drinking Guidelines* (NHMRC, 2009 sets them as 'no more than two standard drinks on any day and no more than four standard drinks on a single occasion'. It singles out young people and pregnant/breastfeeding mothers, claiming that not drinking is the 'safest option' (NHMRC, 2009). Such blanket judgements about 'safe' drinking levels fail to account for individual and social contexts and therefore do not necessarily equate to reduced harm.

The *Plan* also introduces the idea of 'drinking cultures', that is, 'the values and attitudes and other factors that combine' to shape patterns and practices of alcohol consumption among social groups (SGV, 2012, p. 17). The *Plan* emphasises the need for 'cultural change' to encourage 'healthier social norms concerning drinking, behaviour when drunk, and seeking help for drinking problems' (p. 18). These healthier social norms include 'sensible values', 'individual responsibility' and 'healthier attitudes to drinking and drunken behaviour' (pp.

11, 17). This focus on drinking cultures acknowledges the social contingency of drinking practices and potential harms. Notably, although the *Plan* identifies multiple 'drinking cultures', no comparable notion of 'drug use cultures' appears in the *Plan.* Accepting illicit drug use as a cultural practice would enable recognition of different drug-using practices and the role that social factors play, and better position people to explore healthier consumption practices. Additionally, it could challenge notions of drug consumers as intrinsically socially isolated. Another important point of comparison is the amount of attention awarded to alcohol use and regulation in the *Plan*. This contrasts with the *Strategy*, which touches on alcohol use only minimally[7]. A separate *National Alcohol Strategy* (MCDS, 2006) suggests that there is a greater understanding of and interest in people's relationship to and use of alcohol than other drug use.

Turning to pharmaceutical drugs, the *Plan* describes these substances as working to counter harm in a way that improves 'our quality of life, and saves many lives' (SGV, 2012, p. 25). While the *Plan* clearly acknowledges the benefits of pharmaceutical drugs, it states that these substances also serve to cause harm when they are 'misused'. Misuse is another term (alongside others such as 'risk', 'excess' and 'addiction') used frequently in the *Plan* but remains undefined. Instead, it relies on an assumed common-sense understanding. While never explicitly defined, misuse is linked to practices such as substitution of pharmaceutical drugs for illegal drugs, developing an over-reliance on pharmaceutical drugs, using them while consuming alcohol and trafficking them (p. 25). Unlike the extensive list of harms attributed to illicit drugs, the only harms cited as connected to pharmaceutical drug misuse are road vehicle accidents, addiction and death (pp. 26, 29). The *Plan* states that although misuse of pharmaceutical drugs is a 'serious concern', it 'remain[s] at relatively low levels in the community' (p. 26).

In contrast, illegal drugs are positioned as connected to 'significant harm to individuals and the broader community, including the loss in workplace productivity and the cost to our health and criminal justice systems [sic]' (SGV, 2012, p. 30). Illegal drugs are constituted as

[7] The previous *National Alcohol Strategy 2006–2011* covers Australia's approach to alcohol use and regulation more comprehensively. At the time this research was conducted no *National Alcohol Strategy* was in circulation, but the *National Alcohol Strategy 2018–2026* is now available at <https://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/Consultation%20Draft%20National%20Alcohol%20Strategy%202018-2026.pdf> as a consultation draft. The considerable gap between *National Alcohol Strategy* publications remains unexplained.

directly causing many health and social harms: 'All illegal drugs are dangerous and create unacceptable health risks for the community' (p. 37). Here, pharmaceutical drugs and illegal drugs are presented as intrinsically different. This difference is less concerned with their pharmacology and more concerned with legitimate purposes – as medicine, for treating health problems, or for hedonism/pleasure in the case of illegal drugs. The legitimising effect that medical prescriptions offer for pharmaceuticals is absent for illegal drugs. Illegal drug use (as was seen in the *Strategy*) and misuse of pharmaceutical drugs are implicitly associated with individual failings such as a lack of control and weakness.

What then of alcohol and other drug *use* overall? The *Plan* erases the possibility of illegal drug use without harm. Indeed, addiction is presented as one of the many types of harm that can result. Overall, the *Plan* seems more willing than the *Strategy* to acknowledge different types of use, such as alcohol use for pleasurable purposes and pharmaceutical drugs for medicinal purposes. However, in doing so, this further entrenches illegal drug use as a wholly different bad practice, engaged in by those who lack self-control and fail to embody healthy ideals. In doing so, the *Plan* actively works to prevent safe or enabling environments. While alcohol and pharmaceutical drugs can be subject to misuse thereby causing harm, all illegal drug use constitutes misuse and is inherently harmful.

Framing 'addiction'

As with the *Strategy,* the *Plan* mobilises a range of terms such as dependence, misuse and substance abuse disorder to problematise alcohol and other drug use. Unlike the *Strategy,* the *Plan* specifically uses the term 'addiction' and provides a definition. It defines addiction as 'characterised by chronic and/or persistent behaviour, despite harmful consequences' (SGV, 2012, p. 42). Notable here is that under such a broad definition, any persistent behaviour resulting in harm – for example, playing competition sport – would classify as addiction. According to Moore and Fraser (2013), 'Victorian alcohol and other drug policy and practice produce addiction as a particular kind of problem – a discrete, bounded entity amenable to treatment in episodic fashion' (p. 921). This can be seen in the *Plan* when it uses terms such as 'disorder' (SGV, 2012, pp. 40, 42, 56) and 'condition' (pp. 7, 10, 35) interchangeably to describe addiction and encourages people to connect with 'The most suitable and effective treatment option – from brief early interventions, through supported programs of intensive treatment and withdrawal, and to longer term programs of medication or pharmacotherapy' (p. 42).

As Moore et al. (2015) note, this type of representation depicts people with addiction as 'different from full citizens'; it presents them as 'abnormal, vulnerable, unstable, unhealthy and unproductive' (pp. 422-423). The approaches adopted in both policies (the *Strategy* and the *Plan*) are so general that they are not very meaningful. For instance, people regularly engage or persist in playing sport, yet physical activity is most often linked with health despite the serious harms that can occur. The *Plan* also claims that 'caring for a person with a severe addiction can be complex and challenging' (SGV, 2012, p. 42), without explaining how or why. The 'addicted person' is characterised as the antithesis of the 'healthy' and 'normal' citizen. Although the *Plan* presents as motivated to reject negative attitudes towards people with alcohol and other drug problems (such as addiction), it claims these problems exacerbate other issues, 'such as loss of work, housing, or connections with family and friends' (p. 49). This aligns with the *Strategy's* approach. Claims that the majority of people with addiction do not seek help from health professionals or treatment services also suggest that they are not resourceful, and fail to make the 'right choices' and are not health conscious. They are, therefore, characterised as people who make poor life choices, and in need of external guidance through treatment and care (discussed further below). Importantly, although the *Plan* acknowledges that 'the majority of people with an alcohol or drug problem do not seek help from health professionals or treatment services for their addiction' (p. 40), it does not note that research shows the majority of people who experience drug problems overcome them without treatment (Keane, 2002). According to the *Plan*, it is 'possible to gain control and recover from addiction' (SGV, 2012, p. 42), but there is a need to engage with multiple supports and interventions. However, it also claims that 'both drunkenness and recovery can spread through "social contagion"' (p. 17). This responsibilises individuals and their social networks for 'both positive and negative health consequences' (p. 17) of consumption, and characterises them with a heavily suggestive term ('contagion') freighted with negative connotations.

The ways the *Strategy* and the *Plan* describe people with dependence or addiction overlap in several ways. In both documents, notions of internal weakness, lack of volition and poor life choices circulate. Addiction is presented in these documents as a treatable but relapsing problem which can be either helped or hindered by individual social networks. More importantly, both the *Strategy* and the *Plan* emphasise recovery-oriented treatment as the best response. Although listed as a potential consequence of alcohol and other drug use,

definitions or descriptions of the addiction problem are unclear and multiple. Similarly, in both policies, affected individuals are simultaneously identified as in need of treatment, yet often lacking in the self-discipline to engage with it. Therefore both policies authorise the need for external interventions to enable positive changes.

What should treatment achieve?

As noted in the previous section, the *Plan* suggests that many people who have alcohol and other drug problems do not seek help and are not aware of the harm they cause to those around them. As in the *Strategy*, alcohol and other drug treatment receives significant attention in the *Plan.* Treatment in Victoria incorporates a broad workforce. According to the *Plan* (SGV, 2012), 'Every day thousands of Victorians receive dedicated care and support for their alcohol and drug problems from doctors, psychologists, counsellors, allied health workers, specialist alcohol and drug workers, carers, families and their friends (p. 42). This extensive list helps illuminate what the *Plan* assumes treatment should achieve. It suggests that treatment targets individualised physical, mental health and emotional support. Further, and similar to the *Strategy*, the *Plan* asserts that:

> Better care, treatment and recovery will bring benefits to people with drinking and drug problems through earlier, clinically effective care and support. It will also bring benefits to the wider community through reduced illness, disability, lost productivity, crime, violence, child abuse and suicide. (p. 40)

In listing benefits to the community, the *Plan* makes a significant political intervention. It positions alcohol and other drugs as harmful to everyone, not just those who consume them. While this step could be said to work in support of community acceptance of the costs associated with treatment provision, it also invites further stigmatisation.

In addition, both policies emphasise recovery as a primary goal for individuals seeking or engaging with treatment. Despite using the term 38 times, the *Plan* does not provide a clear explanation of what recovery means. Instead, it is described as a 'journey' (SGV, 2012, p. 30) that enables 'improved health and wellbeing' (p. 49). Here the *Plan* presents care, treatment and recovery as connected terms that rely on each other as part of a unified process. While the *Strategy* advocates treatment as a means of enabling people to recover from dependence, the *Plan* suggests that 'recovery does not depend on treatment alone… everyone in the

community can play a part in recovery by helping to reduce stigma and improve understandings of addiction' (p. 40). It also states at the beginning of the document that 'person-centred care will drive long-overdue reforms, reduce stigma and help recovery' (p. 5). As noted above, linking alcohol and other drug use to multiple individual and community harms sits uncomfortably alongside attempts to reduce stigma. Similarly, 'person-centred care' suggests individuals are the logical target of attention. As with the *Strategy*, people experiencing addiction issues 'are constituted as different from other citizens and must undergo 'recovery' to regain the individual capacities and qualities befitting a resilient liberal subject' (Moore et al., 2015, p. 423). This positions people in treatment as on a path of progress, moving either forward or backwards along the 'right' path to 'positive' change' (Savic & Fomiatti, 2016, p. 14).

A theme addressed in this chapter and indeed in many other critiques of Australian treatment is the notion of evidence-based practice. Policy is represented as a problem-solving activity, but scholars have noted that problems are actually constituted in policy and treatment (Bacchi, 2009; Fraser & Moore, 2011; Lancaster, 2014). Notions of evidence are used to legitimate particular representations, but as scholars have shown, 'evidence' is not stable or neutral. The idea of evidence-based practice suggests objective unassailable truths, but evidence can be inconsistent, collected at the behest of, and shaped by, moral judgements. The *Strategy* claims that evidence supports particular treatment approaches. The *Plan* calls for 'feasible' evidence-based interventions (SGV, 2012, p. 11). It claims the best treatment options range 'from brief early interventions, through supported programs of intensive treatment and withdrawal, and to longer-term programs of medication or pharmacotherapy' (p. 42). In both documents, brief and early interventions are listed together in a way that confuses them. Also, the inclusion of medicine-based treatment leads to further distinctions between drug types (e.g., pharmaceutical and illegal).

In sum, both the *Strategy* and the *Plan* approach treatment as an evidence-based problem-solving activity that centres on 'recovery' as the ultimate goal. However, in both cases, this implies that people who seek treatment lack the individual qualities that allow them independence from alcohol and other drug problems, such as the problem of addiction. Like the *Strategy*, the *Plan* is confident about the effectiveness of treatment and relies on notions of evidence to support this. However, as scholars have pointed out, notions of evidence are problematic. Suggesting that evidence-based practice is a problem-solving activity ignores

how practice may produce the problems it sets out to solve. In later chapters, this thesis will take up the implications of this approach in exploring the experiences of young people involved with two Victorian alcohol and other drug services. While only one of the two services identifies as being 'recovery-oriented', both services attempt to engage in a problem-solving activity. The key difference is what they think the problem appears to be. While Bacchi's WPR (2009) approach is useful for problem analysis, in this thesis I rely on Rhode's risk environment approach (2002, 2009) to explore the ensuing effects and types of environments created when problems are conceptualised in particular ways. I make the key argument that policy and practice present alcohol and other drug use, addiction, treatment, marginalisation and youth in ways that actually work to constitute risk environments. If these issues are reconsidered and their nuances explored, it might be possible to conceive safer environments.

What makes marginalisation?

Unlike the *Strategy,* which uses multiple terms and comprehensively discusses connections between alcohol and other drug use and marginalisation, the *Plan's* consideration of marginalisation is less explicit. In the *Plan,* the notion of marginalisation is present in the 'social determinants of health' (SGV, 2012, p. 47) and 'social factors' (pp. 5, 47, 55) it discusses. More specifically, marginalisation is implicit in four groups singled out for attention: Aboriginal people (especially members of the Stolen Generation[8]), culturally and linguistically diverse (CALD) people (especially refugees), young people (especially 'vulnerable children'), and 'vulnerable families'. As argued in my analysis of the *Strategy*, identifying specific groups serves to marginalise them. Similarly, the reciprocal relationship between alcohol and other drug problems and marginalisation discussed in the *Strategy* analysis is also apparent in the Victorian policy. The *Plan* argues that 'rather than approaching a treatment or health service as a first option, [marginalised people] may be referred as a result of a child protection notification, criminal activity, a driving offence or medical emergency' (p. 44). This comment, while presumably empirically based, serves to reproduce questionable connections made between marginalised people and crime and poor health. In their comparative analysis of Swedish and Australian drug policy, Moore et al.

[8] 'Between 1910-1970, many Indigenous children were forcibly removed from their families as a result of various government policies. The generations of children removed under these policies became known as the Stolen Generations. The policies of child removal left a legacy of trauma and loss that continues to affect Indigenous communities, families and individuals' (Australians Together, 2018).

(2015) note that for 'vulnerable groups 'any substance use, regardless of pattern, is automatically a sign of problematic use or a pathway to dependence, and therefore of potential difference' (p. 423). Singling them out constitutes them as sites for improvement to overcome an implied lack of normality.

Although marginalised people are not singled out in a specific section in the *Plan* (as in the *Strategy*), the approach to marginalisation and the ensuing implications are remarkably consistent between the two documents. Marginalised people are identified throughout the Victorian policy as being particularly vulnerable to harm, more likely to engage in crime, and overall less concerned with health priorities. Marginalisation then, for both policies, is determined by an absence of wellness, which requires external intervention to enable positive change. As explored in the section below, youth are also conceived in similar, vulnerable, ways. When coupled together, young marginalised people are especially targeted in policy, which has flow-over implications for how they are conceived in other (e.g., physical and social) environments.

What characteristics define youth?

Unlike the *Strategy,* the *Plan* does not explicitly identify 'age and stage of life' as key to making people especially predisposed to alcohol and other drug harms. However, it does consistently refer to youth. It argues that youth engage in risky and unstable drinking practices, and recommends the need for effective education and improved links between mental health and alcohol and other drug services. The *Plan* argues that 'education helps to delay use, reduce harm and increase wellbeing and resilience among young people' (SGV, 2012, p. 20). This linking of education and mental health implies that if young people are aware of the harms, and possess the necessary mental fortitude, they will not engage in drug use. Personal wellbeing and resilience are positioned as the antithesis of alcohol and other drug problems. As discussed above, pleasurable drug consumption does not figure here. This is consistent with Australian drug education, which is, in part, informed by alcohol and other drug policy. As Farrugia (2014) notes, 'bodies that enjoy a long-term and unproblematic relationship with the drug are simply non-existent in Australian drug education' (p. 669). They are similarly absent in national and state alcohol and other drug policy.

As with the *Strategy,* young people are presented as predisposed to risk taking. While the *Plan* conceives alcohol use as potentially harmful and drug use as inherently harmful,

positioning young people as risk takers changes the discussion from being about young people 'at risk' to young people 'as risk' (Crowe, 2016, p. 3). In analysing secure welfare services in Victoria, Crowe notes that 'while risk is a key emphasis in data sources as the justification for intervention, it is characterised simultaneously by multiple meanings and vagueness' (p. 6). In these policies, young people's lives become a site for intervention, targeted in the hope of instilling 'sensible' values and individual responsibility, an increase in social confidence and decision-making skills (SGV, 2012, p. 21).

One particular site of intervention that both policies advocate is that of the family. As discussed in relation to the *Strategy,* families are held responsible as providers for young people's complex needs. According to the *Plan,* the Victorian Government has 'changed the law on the secondary supply of alcohol to minors to give parents back the power to make decisions about whether their children will drink alcohol' (SGV, 2012, p. 11). However, the *Plan* and the *Strategy* both position families as sources of 'negative' influence as well as 'positive' influence. As the *Plan* puts it, 'Parents and families need to be mindful that their own attitudes and behaviours toward alcohol can influence their children's attitudes towards alcohol. This influence is most often positive. However, it can be negative' (p. 20). In this extract clear distinctions are drawn between right and wrong types of drinking. While some drinking brings benefits such as 'vibrant, liveable cities and regions, prosperous businesses, and good times with friends' (p. 10), other types lead to 'violence and verbal abuse… health problems and a loss to productivity' (p. 10). However, as Keane (2009) argues, intoxication cannot be reduced to this binary as it 'is embodied, social and situational rather than an abstract and universal category with a fixed meaning' (p. 141).

As is the case with the national *Strategy,* Victoria's *Plan* takes up dominant discourses of young people as underdeveloped bodies, inclined to risk taking and vulnerable to harm. Importantly, both policies emphasise the family institution as responsible (at least to some extent) for young people's consumption. This narrow explanation ignores young people's understandings and experiences of alcohol and other drug use. Instead, as I will argue when I analyse the interviews I conducted with young people, we need to rethink these simplistic versions by exploring the richer and more nuanced accounts given by young people themselves. Doing so will open a range of opportunities to young people. In this policy environment young people are simultaneously vulnerable and risk-taking subjects. This

encourages stigma about young people as risky and untrustworthy and it does not allow young people to resist, reject or negotiate this stigma.

Conclusions

While alcohol and other drug use is addressed in Australian and Victorian policy, young people, especially those who are marginalised, are often overlooked, or unjustifiably problematised in these documents. Although the addiction phenomenon has gained such currency that it is attributed to an ever-wider range of activities, the 'problem' of addiction is still most commonly reserved for those who have less capacity to resist it. By this, I mean that while activities such as gambling, sex and shopping are considered addictive, those who are awarded the stigmatising label of 'addict' are often already marginalised.

In this chapter I presented a detailed comparative analysis of the representations of alcohol and other drug use, addiction, treatment, marginalisation and youth in Australian and Victorian drug policy. Drawing on a risk environment framework, the policy environment can be seen to produce a particular discourse. Notions of risk, harm and problems that circulate in these policies are embedded in preconceived assumptions and biases, from which a particular type of subject is made. In these policies, the marginalised young drug-using subject epitomises the antithesis of the healthy liberal citizen. Safe social drinking is reserved for the well-controlled and rational adult thinker, while marginalised young alcohol and other drug users are linked to crime, trauma, poor health and a loss of volition.

As I have argued, the *Strategy* and the *Plan* both connect alcohol and other drug use to multiple physical, mental and social harms. In doing so, these substances are often presented as the cause of these harms. People who experience harm from alcohol and other drug use are depicted as flawed and lacking the internal resources to cope with challenges and change. Although some recognition is given to pleasure, consumption is mainly presented as harmful and dangerous, negatively affecting individuals, families and communities. A potential effect of alcohol and other drug use, according to the *Strategy*, is dependence, and the *Plan* adopts the same approach, using the term 'addiction' instead. 'Dependent' or 'addicted' users are defined by their inability to make the right life choices and their lack of emotional resilience. This serves to blame them for their circumstances and hold them and their families responsible for any problems they experience. For those who do experience problems, the policies endorse multiple forms of treatment, emphasising preventive strategies and brief

interventions as the most viable and economical ones. However, despite repeated claims that Australian treatment is evidence-based, and that the *Strategy* supports 'what works', research suggests that treatment outcomes and definitions of success are far more complex. What works, and the effectiveness of treatment, must be measured against multiple and varied aims and differently assessed outcomes of service and government objectives. Chapter Five explores the tensions between young people's goals and priorities for treatment and the objectives of the services they attend.

A range of groups are identified in the *Strategy* as being at risk of, or already experiencing, social isolation and disadvantage, including homelessness, poverty, family breakdown and illicit drug use (MCDS, 2011, p. 6). In the *Plan* the notion of marginalisation is present in references to 'social determinants of health' (SGV, 2012, p. 47) and 'social factors' (pp. 5, 47, 55). More specifically, marginalisation is implicit in four groups singled out for attention: Aboriginal people (especially members of the 'Stolen Generation'), CALD people (especially refugees), young people (especially 'vulnerable children'), and 'vulnerable families'. I draw on a different definition of marginalisation from that implied in these policies, framing particular groups of people via a deficit model – as lacking life skills and in need of external influences to enable positive change. In contrast, Victorian and national policies present marginalised people as sites for improvement so that they may overcome an implied lack of normality.

Young people are conceptualised in similar ways. Described as predisposed to taking risks, they are sites for increased state and family surveillance. Their alcohol and other drug use is explained by an innate curiosity, an absence of control and a need to cope with trauma. Of particular interest for my thesis is the way neuroscientific discourses are taken up and used to explain young people's increased risk of harm. Arguing that their brains are not fully formed, the *Strategy* depicts young people as a highly volatile and vulnerable group who require increased regulation to delay and curb their alcohol and other drug consumption. However, young people are not a homogenous group, and their experiences can vary profoundly by gender. Australian and Victorian policy would benefit from a better recognition of these differences and their respective implications.

Alcohol and other drug consumers are presented in policy as vulnerable to multiple types of harm, including dependence or addiction. Implicit is the notion that treatment aims to create

change in the individual and their consumption practices. They are, therefore, characterised as people who make poor life choices, and in need of external guidance to enable them to make the 'right', healthier life choices. The policies' selective list of people who experience, or are at risk of experiencing, social ostracisation and disadvantage further confirms stereotypical notions of normality, from which alcohol and other drug users are often excluded. The connections drawn between marginalisation and alcohol and other drug use – a reciprocal relationship in which each causes and confirms the other – can be said to further marginalise them. The presentation of young people as vulnerable, at risk, incapable of making safe and healthy choices and requiring intervention also serves to further problematise and marginalise them.

This analysis raises questions about whether excessive, disproportionate or insufficiently nuanced attention to these harms, and the stigma that can accompany this attention, may serve to further problematise particular alcohol and other drug consumers and indirectly increase harm. I suggest a need instead for a more careful discussion of the wider range of reasons that people engage in alcohol and other drug consumption, which could lead to a broader understanding of the issues and ultimately to less marginalising approaches. This discussion is taken up and explored in Chapter Five of this thesis.

Chapter Five: Making meaning of alcohol and other drug use in youth treatment engagement

In my literature review in Chapter Two I traced the sociology of addiction. The literature presented shows addiction as both socially constituted and materially real. As Fraser et al. (2014) put it, addiction is 'an unstable assemblage made in practice' (p. 235). In Chapter Four, I examined this instability in key Australian and Victorian policies. There, I revealed how Australian and Victorian drug policy problematises alcohol and other drug use, addiction, treatment, marginalisation and youth, and how policies function as key sites in the construction of problems (Manton & Moore, 2016). In short, Australian and Victorian policy works to produce the very problems it aims to address. In this chapter I move from analysing policy texts to analysing the interviews I conducted with young people so as to focus on the first of two issues of central interest to this research: how alcohol and drug use are constituted in youth alcohol and other drug treatment service engagement.

In this chapter I explore how young people who access services conceptualise alcohol and other drugs and addiction, and more importantly, how the risk environments they operate in work to constitute these ideas. In conducting my analysis I keep in mind the broader policy framework in which services and their clients must operate. As seen in Chapter Four, 'harm minimisation' is the key approach adopted in Australian and Victorian policy. Also, young people are framed as both vulnerable to risk and instigators of risky behaviour. As I have argued already, however, risk avoidance is an unrealistic goal. Instead, it is more beneficial to understand and explore how young people engage with and negotiate the risks they experience.

This chapter begins with a description of how the two Victorian services I recruited from approach treatment, and how they frame alcohol and other drug problems. I assess their overarching philosophies and consider the implications these have for clients. Following this, I draw on participant interviews that discuss what they wanted from their service contact. My analysis draws attention to the reasons that clients cited for their service engagement and takes a step towards exposing mismatches that exist between client needs and the intentions of the services. Finally, using a case study approach, I draw on four participant narratives to develop an in-depth understanding of perspectives on alcohol and other drug use and how these relate to their service experiences. These narratives demonstrate how interactions with

services work to constitute ideas about use and self-conceptions and the multiplicity of ideas circulating around consumption practices.

Service A and Service B: Approaches and objectives

Participants in this study were recruited from what I have called Service A and Service B. Although both facilities offer support and treatment specifically for young people, this is done through different programs, resources and approaches. Service A also offers other programs and support to adults, while Service B only provides for youth. In Chapter Three, the basic details of these services were provided, including what services they offer, how many clients they have supported and how long they have been in operation. Here, I look more critically at their approaches and treatment objectives.

In Chapter Three I noted that Service A offers a 'recovery-oriented' approach that also incorporates housing, education, advocacy and family support. The *National Drug Strategy 2010-15* (MCDS, 2011) states that 'the harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco, and other drugs is well known' (p. 2). Service A's mission statement is an example of how youth services reflect and take up national approaches to treatment. The emphasis on 'individuals, families and communities' is echoed down through Australian and Victorian policy into procedures at the micro level. Where the government identifies harm, Service A offers opportunity and recovery. Service A's objective to enable people to 'achieve meaningful, satisfying and contributing lives' suggests that they conceptualise addiction as a meaningless and selfish condition. Of note is the service's frequent employment of the term 'addiction'; this runs contrary to Australian and Victorian policy, in which the term 'dependence' is more commonly utilised.

'Recovery' is another term this service utilises heavily. This highly contested and emotive term has attracted significant scholarly attention. Research in the field has worked towards highlighting the implications of recovery identities (e.g., Fomiatti, Moore & Fraser, 2017) and how they shape self-conceptualisations. For Service A, recovery is underpinned by an emphasis on the 'wholeness and wellness of the individual and community' (2015, p. 9). The treatment it offers is based on the ultimate goal of 'recovery', which is conceived as a collective peer-based exercise, in a move that suggests addiction is an illness best treated through being enmeshed in a community, and that lack of community is at least part of the problem.

Service B's approach is basically that of harm reduction. This does not mean it avoids diagnostic terms or categories. Contrary to Service A's use of the term 'addiction', Service B's preferred terminology is 'substance dependence'. According to its 2014 annual report, 'Up to 5,300 young Victorians (10-22 years) have substance dependence, a chronic and relapsing condition, and complex psychosocial problems where both their drug and alcohol use and vulnerability are severe' (p. 6). This reference to substance dependence as a 'chronic and relapsing condition' suggests that for Service B, it is an enduring ailment. Although this may initially appear similar to the way that addiction is conceptualised by Service A, the implications are different. Service A uses labels such as 'addict', while Service B focuses more on the experiences and effects of young people's consumption practices. This is complicated, it is argued, by experiences of 'complex psychosocial problems' (2014, p. 6). Although Service B separates substance dependence from psychosocial problems, they are presented as inherently connected. This implicit connection reflects the dominant approach to young people's consumption practices as outlined in both national and state policy, as discussed in Chapter Four.

On its web page, Service B notes that it works to 'engage, support and strengthen highly vulnerable and high-risk young Victorians affected by, or at risk of being affected by, alcohol, drugs, mental health issues and social disconnection' (2013). Incidentally, Service A and Service B both refer to social integration/disconnection as problematic and worthy of attention. By doing so, they conceptualise alcohol and other drug problems and addiction as inherently linked to social isolation.

In sum, the two services offer different approaches to alcohol and other drug use and addiction. Service A is a recovery-oriented organisation, which actively uses the term 'addiction'. In part, this involves attributing addiction labels to clients through the '12-step'[9]

[9] The 12 steps are: 1. We admitted we were powerless over alcohol – that our lives had become unmanageable. 2. Came to believe that a Power greater than ourselves could restore us to sanity. 3. Made a decision to turn our will and our lives over to the care of God as we understood him. 4. Made a searching and fearless moral inventory of ourselves. 5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs. 6. Were entirely ready to have God remove all these defects of character. 7. Humbly ask him to remove our shortcomings. 8. Made a list of persons we had harmed, and became willing to make amends to them all. 9. Made direct amends to such people wherever possible, except when to do so would injure them or others. 10. Continued to take personal inventory and when we were wrong promptly admitted it. 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge

(Addiction Centre, 2017) process. It offers several programs, which cater for a wide age bracket. The service offers one particular program (a residential support service) that is youth specific. Some participants in this study were recruited from this program (from one site). In contrast, Service B is essentially a harm reduction service. It uses the term 'substance dependence' and gives greater recognition of and attention to comorbidity. It is specifically a youth-oriented service and offers multiple programs across sites spread throughout Melbourne. I recruited participants from two of Service B's sites and engaged with several different service programs (day program, counselling and detoxification). Notwithstanding the differences between the services, both emphasise social disconnection as a key problem, and include family support and integration in their approaches to treatment. Further, they both offer support specifically for young people experiencing alcohol and other drug problems, and offer multiple resources to their clients in the process.

Prompting engagement: What do young people want from services?

One area of the interview focused on asking participants about what they aimed to achieve from their service contact. Despite some differences, there were key consistencies across participant's accounts. Some of these consistencies held true irrespective of which service they attended, while others were service specific. In the section below, I present the three key reasons cited for service engagement: access to housing and other resources related to food and hygiene; a perceived or actual restriction of choice; and to make changes to their alcohol and other drug use. Further, I draw out connections between the reasons cited for service engagement and which services were engaged with. Of interest is that, despite accessing alcohol and other drug services, changes to their consumption practices formed only one aspect of their reasoning for service contact. As shown below, in most instances, participants had more pressing concerns and cited multiple reasons for service engagement.

Of the 19 young people who took part in this research, eight explicitly stated that housing and homelessness problems contributed to service contact (with either the service they were recruited from or other housing-related services). Even more participants referred to having a safe place that they could access as being important to them. Service A offers accommodation as part of its youth program and Oliver, Chloe, Melanie and Moira[10] all

of His will for us and the power to carry that out. 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principals in all our affairs.

[10] To ensure the anonymity of participants in the study all names used in this thesis are pseudonyms.

mentioned this as being relevant to their decision to engage with the service. For instance, Moira (female (F), aged 19 years, with methamphetamine as her predominant drug use, Service A) decided to enter detox after the car she was living in was stolen:

> I [went] to detox […] so I could have a roof over my head. Because I was just, like, I had no car, and nowhere to live, no money left, just everything was gone, I had no friends, […] and then I went into detox.

After completing detox she entered Service A's youth program and gained permanent housing through that. Engaging with a detox facility is a requirement of entering the program. Another participant, Melanie, (F, 24, methamphetamine, Service A) offered a similar account:

> I didn't know where I was going after the detox, so like I pretty much came here, because like I couldn't go back home. […] I didn't have a job, I couldn't move back in with my sister after everything I had done, umm and I guess something inside of me wanted to be clean and I knew that I had a house here, there was people around the same age and yeah, it was getting out of my like home town kind of thing.

Although Melanie offers up housing as an issue, she also employs the stigmatising term 'clean' to describe a change she wanted to make to her consumption practices. As shown later in this chapter and in Chapter Six, employing the term 'clean' was common amongst Service A clients and it is also indicative of the ways that participants adopted particular approaches to addiction. Like the participants recruited from Service A, who mentioned (and gained) housing as part of their service engagement, Service B clients cited housing and homelessness as key concerns. Incidentally, it was often through their contact with other services (such as housing agencies) that participants became aware of Service B. For instance, Victor (male (M), 18, alcohol, Service B) was seeking housing, and in turn was linked to other services that offered welfare support:

> I came to [Service B] because I didn't eat for like weeks on end and [a worker from a housing agency] told me to come down here and they could support me with food and showers and clothes and stuff like that, so I came down here.

Engagement with Service B gave Victor access to food and washing facilities and allowed him to discuss his alcohol consumption with workers. However, at the time of the interview he was still homeless. Another participant from Service B, Niles (M, 19, methamphetamine) cited homelessness in his interview, but also mentioned several other concerns:

> That would've been the fact that I've got nothing else to do with my life right now, I've got no money, I've got nowhere to go, I'm homeless, I just need to get into rehab like to give myself a break and get a bed basically. So coming here was a step closer towards that.

These comments suggest that Niles understands his service contact as a process, in which several goals need to be met progressively. By engaging with Service B, Niles hopes to be able to gain access to a residential rehabilitation service, which will enable him to make changes to his current situation. Interestingly, although Niles mentions attending residential rehabilitation, he implies, but does not explicitly state that he needs to change his consumption practices.

Similar to the comments presented above that take up the issue of homelessness as a key factor in prompting young people's service engagement, many of the participants cited either benefits or constraints that prompted service engagement. For instance, Lee (F, 21, heroin, Service B) understood that in order to access government-subsidised hepatitis C treatment she had to abstain from use and demonstrate some 'stability' in aspects of her life:

> I just have to be six months clean. So it doesn't matter if I'm on SUBOXONE[11] that's okay but I can't be injecting. I can't be using […] You have a stable home, good support or else they won't treat you. They're like getting really strict with it now. So umm, they don't even give a shit if you are six months clean. If you are six months clean and you are not stable in the head, they won't treat you, because a lot of people's committed suicide from the tablets [taking Suboxone].

[11] SUBOXONE (buprenorphine and naloxone) is a prescription medication commonly used in Australian to assist in the treatment of opioid 'dependence'. It is used in conjunction with other forms of treatment, such as counselling.

Although I do not explore connections between alcohol and other drug use and medical care in depth, there are many studies of the power inequalities and the stigmatisation of patients with hepatitis C (see Lenton & Fraser, 2016; Rance, Treloar, Fraser, Bryant, & Rhodes, 2017; Treloar & Fraser, 2009; valentine & Fraser, 2008). Similarly, Rhodes, Davis and Judd (2004) and Rhodes and Coomber (2010) apply the risk environment framework to this field and argue that risk behaviour and risk status are two key yet separate ideas circulating amongst people with hepatitis C who inject illicit drugs. In Lee's comments, she alludes to these points and highlights how aspects of her life are being regulated in order for her to be considered for treatment. Marty (M, 20, alcohol, heroin, cannabis, Service B) provides another example of a participant accessing a service as a function of regulation. He explained that:

> It was for my parole obligations, I had to attend drug and alcohol rehabilitation appointments once every week. Also, get assessed every two weeks, what's it called, just come in and talk to them about you know, like, you would, like, are you having any relapses or is there any warnings kind of thing and set up plans in place, so that you don't fall back into that old path.

Despite being compelled to engage with a service, Marty had previously been introduced to Service B as a means of accessing food and showers, and therefore when he was released from prison he nominated Service B as his service of choice. In addition, although Marty explained that the parole obligations involved discussing 'relapses', at the time of the interview Marty was still engaging in alcohol and other drug use and communicated this to his workers.

The third main reason that young people cited for their service engagement was to make changes to their lives, primarily to their alcohol and other drug use. According to Oliver (M, 21, alcohol and methamphetamines, Service A) the primary reason that stimulated him into accessing a service was that:

> I just wanted to get clean. Honestly, I would have gone anywhere. I was just over that lifestyle and what I was doing […] I wanted to change the way I act and the things I do.

Although this statement clearly spells out a desire to change current circumstances and consumption practices, I suggest that the way this is phrased is, in part, a product of his service engagement. While the word 'clean' is not restricted solely to clients of Service A, it is often used by clients engaged with the 12-step model. Further, the disease model of addiction taken up in the 12 steps encourages a self-reflective focus on individual behaviour change. Although I do not dispute Oliver's reasoning for engaging with a service, the language he uses is indicative of the type of service with which he engaged. Another participant, this time from Service B, also cited alcohol and other drug use as a key factor for his service engagement. Similar to Marty, Ari (M, 20, methamphetamine, chroming, Service B) also had parole obligations to attend alcohol and other drug counselling. However, Ari's contact with Service B exceeded these requirements for a different set of reasons. He explained that:

> It's got a computer and food and it keeps me out of shit. Like if I wasn't coming here, I'd probably still be doing drugs as hard as I was or doing something that I used to do. [Service B] keeps me in lock down for five hours a day.

Here, Ari cites three main reasons for attending the Service B day program regularly. It gives him access to resources that he would be otherwise unable to obtain; it aids him in making changes to his substance consumption; and it keeps him in 'lock down'. Employing the term 'lock down' is worthy of attention as it evokes associations with prison, and suggests a connection between consumption and lack of self-control.

The above section provides insight into three distinct reasons that participants cited for their service engagement. As I am particularly interested in understandings of alcohol and other drug use and addiction, as they are made and shaped through service engagement, it is interesting to note that alcohol and other drug use is simply one aspect that stimulates service engagement. It appears that young people who engage with alcohol and other drug treatment services have multiple pressing concerns, and an over-emphasis on or excessive attention to consumption practices could work to create a risk environment in which perceived and actual harms of use receive attention and other areas of need are ignored.

Narrating 'decline': Young people's accounts of alcohol and other drug use

In the report from a large-scale Australian qualitative study of experiences of addiction, Pienaar et al. (2017) note that:

> Addiction is commonly viewed as a disastrous state, associated with decline, misery and loss of control. [However], participants' accounts challenge this view: they show that many people who see themselves as affected by addiction cope and lead rich, full lives. Moreover, their experiences can be understood in ways other than the usual reductive narratives. (p. 5)

In this section I explore how young people in services present their alcohol and other drug use trajectories, finding much in common with Pienaar et al.'s (2017) observation. While Chapter Four explored key policy approaches to alcohol and other drug use, the narratives of the interviews involve much more complicated perspectives. Young people's understandings of their use rarely conform to the narrow approaches articulated in policy, yet at the same time there are elements of overlap. These tensions between overlap and mismatch are the particular focus of this chapter. Despite some commonalities, participants offer complex and nuanced accounts that challenge what is initially presented as a 'narrative of decline'. For this analysis, I focus on four participants, two from service A and two from service B.

Daryn: 'it just tore my life to pieces'

When I met Daryn, he was aged 22 and living in supported accommodation. He had attended Service A's recovery support program five days a week for the previous 14 months. Outside of program hours, he elected to attend additional Narcotics Anonymous meetings and said he had formed new friendships with people he met in meetings. His narrative is similar to many others I heard during interviews. First, alcohol and other drug use is not always described in relation to negative consequences. On many occasions, many interviewees presented it as enhancing entertainment and social interaction. Researchers have explored alcohol consumption and the constitution of friendships (Guise & Gill, 2007; MacLean, 2016) and the role alcohol plays in social and leisure pursuits (Coleman & Cater, 2005; Goodwin et al., 2016). Equally, many scholars have analysed how the normalisation of alcohol and other drug use allows particular types of use to be situated in young people's leisure pursuits (Duff, 2005; Measham, Newcombe, & Parker, 1994; Parker, Aldridge, & Measham, 1998). Although my project focuses specifically on marginalised young people's use and treatment

experiences, I founds much in common with these literatures, including the positive and enjoyable experiences embedded in consumer accounts. Also found in both the literature and my interviews was an emphasis on the social and physical environments in which use occurs, and how these often shape alcohol and other drug practices (Duff, 2008, 2011, 2012; Ennett at al., 2006; Foster & Spencer, 2013). Place, it is clear, has a significant impact on how and which substances are consumed. Despite the diversity of experiences, however, they invariably become integral elements in a story of decline. Illuminating these points is an extract from Daryn's interview (M, 22, methamphetamines, Service A):

> Like at work, it was good in the social side of things, like it gave me a lot of confidence and that sort of stuff. Like I had fun, at the start [...]. But like on the flip side, like I'd spend my whole pay like the day I got paid, to have enough for the weekend or whatever. Um, yeah and like, [I was] not being there like emotionally for my family or anything like that. Like I was just… never around, like never around for anyone. I just blew off all my mates staying out with like – I left the smokers' group. I used to just hang out with my boss and my co-worker on the weekends and stuff, and yeah. It just tore my life to pieces really, eventually.

Here, Daryn begins by describing some of the positive aspects that he gained from his use, such as increased confidence. However, he also explains that he was 'never around, like never around for anyone. I just blew off all my mates'. Although his use facilitated new friendships with his boss and co-worker, Daryn's comments focus on lost friendships to demonstrate how his drug use affected his life negatively.

The 'smokers' group' was a friendship group Daryn met through school. Together they smoked cigarettes and consumed cannabis and ecstasy either at school or at parties on the weekend. According to Daryn, his time with this group was 'fun', 'sneaky' and 'rebellious'. However, after being expelled from school he found employment in the building industry and his alcohol and other drug use patterns changed, firstly into regular drinking and then amphetamine use (and then 'ice' (methamphetamine) use) with his boss. As Daryn put it, his drug use 'tore' his life 'to pieces'. When questioned on this, Daryn explained that:

> speed started getting a bit old and I got, I got into the ice, um, yeah and like, by doing that I met this different, these different group of people, you know, like hanging out

> with dealers, stuff like that. Um […] the ice took a hold and became like my priority in life. Like I wasn't worried about work, I wasn't worried about family or anything like that. So long as I had ice and I was with someone else who had some, so I'd never run out you know? Um yeah like, I dunno like, it all just turned really dark.

Daryn went on to tell me that he became engaged in crime (stealing, robbery and drug trafficking), and he was charged with the latter. He believes that his drug use directly contributed to being told to leave home, and to his parents' divorce. In this excerpt, Daryn mentions the environments and company he would seek. Methamphetamine use prompted socialising for Daryn. Also of significance is his depiction of methamphetamine as an active agent that 'took hold' of him. Here the drug is not just understood as a product for consumption, but an active agent shaping choices and control. Attributing specific characteristics to particular drugs is arguably partly a product of treatment engagement. For instance, although Daryn never used heroin, he claims that since 'coming into recovery' he has developed a fear of injecting it because of 'how bad it can turn your life quicker'. Here, both the drug and mode of use are ascribed particular demonising characteristics that are bound up in a narrative of decline. Drugs are seen as causal agents with negative consequences such as engagement in crime, loss of family connection and finances. The pleasurable and productive aspects of drug use simultaneously drop from view. Further, under the abstinence-based approach that Service A employs, all alcohol and other drug use is considered harmful. In this sense, abstinence-based approaches obscure any pleasure-based consumption, while also serving to responsibilise individuals for the perceived harms of all use. This creates an environment in which the harm of consumption is made in day-to-day interactions (Rhodes, 2009).

Chloe: 'I wasn't ready to give up my drugs'

Chloe was 24 years old at the time of interview and also living in supported accommodation. As part of the requirements of Service A's recovery support program, in which she took part five days a week the previous year, Chloe also attended Narcotics Anonymous meetings. Chloe began drinking alcohol at age 16, and recalled the social and physical risk environments she engaged in (F, 24, methamphetamines, Service A):

> So it started off on a Friday night. You know, when I was younger it was only just a Friday and Saturday night. I would go out and get really drunk and just end up in

> places that I didn't know where I was. I'd go home with people that I didn't know, I'd, um, drink and drive you know stuff like that… but I didn't care, because when I had a drink in me, I thought I was, I thought I was bulletproof.

Chloe's recollection of her drinking experiences is interesting for several reasons. Like Daryn, she cites increased confidence ('I thought I was bulletproof') as a positive effect of her consumption. Similarly, she talks about people and place as critical actors in constituting the risks of excessive drinking. Despite this, drinking alcohol also enabled positive physical and social environments:

> Yeah, see like I had heaps of fun… Like you know, dancing and having fun and just being, like, a girl, you know, having fun with your girlfriends and meeting new people and stuff, so like that was really fun.

Here, Chloe frames her alcohol use in relation to her gendered experiences of socialising (see Goodwin et al., 2016; MacLean, 2016). For her, drinking experiences involved 'being, like, a girl'. Given modern speech conventions, I suggest that the word 'like' is used here as a 'discourse marker' or a filler (Hitchens, 2010). When asked to clarify, she explained that her drinking was intertwined in social 'events' (see also Dennis, 2016; Dilkes-Frayne, 2014) that also involved 'dressing up', 'making myself look pretty' and 'getting attention' from men. Drinking alcohol forms only one aspect of these events, and is used primarily (in this instance) to facilitate fun while engaging in the other activities of 'being, like, a girl'. Despite these positive recollections, Chloe's narrative exhibits a trajectory of decline similar to Daryn's. When Chloe formed a relationship with a man eight years her senior, her consumption practices changed significantly. She explained that he had been 'smoking ice [methamphetamines] for like, 10 years […], he gave it to me, and I kind of never looked back since'. Chloe described how she began to consume methamphetamines with increasing frequency until it became a daily activity:

> I started smoking [ice] every day and then I lost my job. [….] So I was with this guy, and we were living together in this house and like ours was like the party house and everyone used to come over. […] So this was, yeah, when I was 19, before I was with this previous boyfriend, I tried to get clean, because I lost a job and my brother and my stepdad came and found me at my boyfriend's house at the time. […] He was really abusive to me, he used to bash me and like kick me out of his house and, umm,

> yeah just getting involved in stuff that I didn't…. and I was scared. I didn't want him to leave me and he made me feel like that no one else would ever want to be with me, so he would feed [me] more drugs […]. So I lost that job, and then I tried to get clean. And I stayed clean for like thirty days. And I just wasn't ready. Like I wasn't ready to give up my drugs.

Despite citing examples of how her recollections fit into a narrative of decline, Chloe continually includes references to socialising and breaks from drug use in her narrative. These challenge conventional accounts that assume drug use events flow in one direction towards a low point or catastrophe. Although Chloe cites losing jobs as an example of her decline, she also explains later in the interview that these were 'pretty good jobs' and she worked full time in managerial positions. Clearly, Chloe was generally a highly competent and active person, even if at times her circumstances deteriorated. Additionally, as Pienaar et al. (2016) note in their recent report, people often use 'informal strategies' to 'make changes when necessary to limit the risks they see as related to more frequent consumption' (p. 22). Instead of framing her self-initiated break from consumption as a positive risk management technique, Chloe presents its temporary status as a failure, or a sign of being unready to change, mobilising the highly stigmatising term 'clean' to describe her experience. Being 'clean' is a common expression used in 12-step meetings (in which Chloe was heavily engaged). It works to produce alcohol and other drug users as dirty, or less than whole people. Similarly, her comment that 'I wasn't ready to give up my drugs' is reflective of Service A's philosophy that complete abstinence is the ultimate goal, while continued use is selfish or a sign of failure. Chloe's narrative raises several issues concerning her use and how these ideas are shaped through her interaction with a recovery-oriented, abstinence-based approach. However, she also raises the issue of gender and how that shaped her consumption experiences. As scholars have noted, 'post-structuralist approaches encourage a focus on how class, gender and other structural factors are lived through *participation* in drug use and local drug economies' (emphasis in original) (Rhodes, 2009, p. 198). Chloe's narrative demonstrates how the risk environments she engaged in were shaped uniquely by her understandings of gender and her negotiations of risk and pleasure.

Esther: 'I still like tripping, I'm just more aware of it'

The third case in this section comes from an interview with 21-year-old Esther (F, 21, hallucinogens, Service B). Unlike Daryn and Chloe, both from Service A and heavily

involved in 12-step fellowship teachings, Esther had been a regular visitor at Service B's day program for four years. During that time she had sought counselling from service B and another youth-oriented service. Having experienced extended periods of homelessness, at the time of the interview Esther was renting accommodation and receiving payments from Centrelink. As with the first two examples, Esther offered a narrative of decline for her alcohol and other drug use. This narrative is a rich example of how 'decline' is often an alternating mixture of positive and negative experiences, and changing patterns of use, all of which draw on and reproduce familiar ideas about alcohol and other drugs.

> I started with pot and prescription drugs like Valium. One time I took lithium and that was really not good and instead of making me happier and giving me emotions, it made me more emotionally numb and more depressed and more unhappy. I've never been too keen for pot. Some people like it. And then I took LSD[12], and I was kind of temporarily, I had more motivation in life. I was like — I found there was more meaning to life after I took my first tab, but it also kind of started me abusing psychedelics after that, so I took it too often […] It made me feel, and that's what I wanted. I wanted to feel things, and I wanted the world to have meaning in it again, and that's what it gave me.

Esther's account provides unique insights into how she understands different types of drugs. For Esther, particular drugs help fulfil particular roles. As Hughes (2007) argues, for some, drug use 'is predicated upon, and productive of, purposeful drug-using relationships in which users produce and reproduce the conditions for continued use' (p. 673). Drawing on these ideas, I suggest that people's drug-using experiences and practices can be understood as relationships; the act and the experience of consumption continually shape understandings of both the self and the substance. Ironically, and despite Esther's identification of positive aspects to her LSD use, at the end of the interview she added, 'so, happy people just don't take ice or heroin, happy people have something to fulfil in their heart'. Here, Esther frames drug users as unhappy and in a state of despair. This aligns with her earlier comments when she explained that she felt: 'no one cares about me, I don't care about me, so I'm just going to screw myself over and do drugs'. However, as shown above, this approach is complicated by

[12] Lysergic acid diethylamide, known as acid, is a substance, which when consumed may result in hallucinations. It is only one type of hallucinogenic drug and is reported to increase feelings of euphoria and relaxation.

the relationship she had with LSD, in that she felt it helped her gain 'meaning' in her life. Her view appears to have changed when she began experiencing other effects from LSD: 'My trips started turning really sour. I started getting panic attacks, I started getting anxiety, my teeth started hurting'. After an excursion into the Victorian snowfields with Service B, she temporarily ceased all drug use because it have given her things she had neglected to give herself: '[I got some] exercise, which I hadn't had in so long, I was eating good. I was breathing fresh air'. When asked about whether she saw alcohol and other drug use as being part of her future life, Esther said:

> Maybe occasionally, once every six months, MDMA[13]. I'm not really ready for drugs at the moment, so maybe once a year, acid. I still like tripping, I'm just more aware of it and that it can drive me into insanity.

As in the previous case studies, Esther's narrative raises questions about straightforward accounts of decline. Her drug use experiences involved both positive and negative elements that at times overlap and contradict each other. The perspectives offered in her interview, and in the others too, are far richer and more nuanced than those offered in the policy documents I have analysed. Notably, Esther's relationship with LSD is contingent on achieving certain positive effects and avoiding the negative risks and effects she associates with it. In these ways, all three participants have much in common. Yet differences are also apparent. Unlike Daryn and Chloe, Esther is not undergoing abstinence-based treatment. Having taken part for many years in Service B's programs, Esther offers a less rigid picture of her future relationship to drugs, and a more complex account of different types of drugs and their multiple effects. On Service B's homepage it is stated that 'more than half of the young people [Service B] supported in 2011/12, ceased or significantly reduced their drug use' (Service B, 2013). This comment suggests that consumption is simply one of the areas that Service B addresses, alongside other welfare-focused supports. Esther intends to negotiate her future drug use through her understandings of the multiple effects, benefits and risks of use. Her narrative highlights the '"nonlinearity" of interactions in the difficult to delineate pathways between environments and drug harms' (Rhodes, 2009, p. 193). Esther negotiates in and out of multiple risk environments, in which she both embodies and adapts to risks she encounters.

[13] Methylenedioxymethamphetamine, commonly known as ecstasy (MDMA) is classed as a stimulant and is effects are reported as increased energy and confidence levels. Although it is rare, it has been reported to also produce hallucinations.

Maurice: 'If you want to do it, just do it respectfully toward yourself'

The final interview explored in detail here was with another participant from Service B. I met Maurice when he was 19 years old and was 'couch surfing' around Melbourne's inner suburbs. He was receiving regular payments from Centrelink[14] and was involved with Service B's day program and activities. Maurice cited many reasons for his involvement with this service and also stated that the service had addressed many, but not all, of his needs (such as his housing situation). Although alcohol and other drug use had been problematic for him, Maurice also cited other health concerns that affected his wellbeing. Prompted by these multiple concerns, Maurice explained his involvement in this research as his attempt to assist others in making 'life choices'. This notion of choice is particularly interesting for my project, and is explored more in Chapter Six, as it invites the recognition of individual agency, which is often absent in dominant discourses of addiction. In explaining this, Maurice (M, 19, alcohol and synthetic cannabis, Service B) cited instances when he had been prompted to, and engaged in, what he termed either 'good' or 'bad' decisions:

> It's your decision whether you want to be good or bad. But in the same sense, when you're young, you get influenced very, very much and if you have no one and then you've just got your mates, and your mates are doing them things [alcohol and other drug use, crime], you are going to be influenced by the bad things and then you grow up doing the same things. But if you've got someone to sit there and say, 'look, you've got other options' and they guide you this way. But I never had that. I just learnt the one way and grew up that way. But now I'm slowly changing because I've got people [Service B workers] talking to me now as I get older.

In this passage, Maurice raises several key issues. Firstly, he creates a binary between good and bad decisions. Secondly, he reproduces a dominant narrative of young people as at risk of negative influence and peer pressure (Farrugia, 2014; Farrugia & Fraser, 2017). Thirdly, he raises the idea that services can provide a new direction, creating change, and filling a void in which 'good' advice is lacking. In relation to this last point, unlike Service A participants who spoke about complete abstinence, Maurice said that although he was still using alcohol and other drugs, Service B aimed to help 'try and lead us to a different sort of life'. Further,

[14] Centerlink is part of the Department of Health and Human Services and it delivers social security payments and services to eligible Australians.

although he spoke with workers at Service B privately about his use, he explained that 'we're actually not allowed to talk about drug and alcohol use while we're in the day program'. This rule is in place so as not to 'trigger'[15] (Dennis, 2016) anyone else in the program who may be abstaining from use. However, Maurice's private discussions with his worker centred on harm minimisation:

> Yeah they try and cut down your usage, that's the main thing about harm minimisation, that's the main thing […] he's helped me along the way, he's like 'I want you to try this and get a goal' and that's what I've done […] It's just that sort of stuff about just taking care of yourself while you're doing it. If you want to do it, just do it respectfully toward yourself. Don't go over the top.

This quote again illustrates the kind of connection that can arise between a service philosophy and the outlook of a service user. Like Service B, Maurice's account is oriented towards harm reduction, and does not offer a singular trajectory of decline. While Maurice reports problems connected with his use, he is now also establishing ways to moderate his use and to 'do it respectfully toward yourself'. The idea that alcohol and other drug use can be moderated and enjoyable challenges notions of inevitable compulsion and disorder, and creates room for support among those unconvinced by one-way decline narratives.

In this section I explored the narratives of drug use offered by participants, focusing on the narrative of decline. As I noted, some participants reproduce these narratives, while others do not. Importantly, even where such narratives are offered, they contain within them observations and references that challenge such straightforward accounts. As Huggins (2006) notes, 'representations of drug use are complex, often contradictory and ambiguous' (p. 167). Although all these narratives include elements that fit into a narrative of decline, other aspects highlight how alcohol and other drug use can be purposeful, enjoyable and beneficial. The responses from the four participants quoted above highlight that consumption practices are often specifically designed to achieve particular effects and experiences, and that consumption does not necessarily directly correlate with problems. By doing so, these

[15] Dennis (2016) considers 'triggers in terms of "the event", and the body as something we *do*, neither subject/object nor body/world pre-exist each other' (p. 126). By doing so, she highlights the complex relationships that people have with drugs and moves beyond Enlightenment notions of rationality and reason. This offers an alternate account of alcohol and other drug users as plagued by loss of self-control and volition.

accounts undermine public and policy discourses that consider drug use as inherently destructive and indicative of lost volition. In terms of risk environments, I suggest that Maurice accesses a supportive environment because it does not demand abstinence. Narrow accounts of the 'right' way to deal with drug use could be considered risky because they exclude people and create feelings of failure and unworthiness. Comments from Daryn and Chloe earlier in this chapter support this notion.

Conclusions

My analysis in this chapter explored how ideas of alcohol and other drug use are encountered and engaged with in Victorian youth alcohol and other drug services. As I argued earlier in this thesis, alcohol and other drug use risks are propagated in public and policy discourse. Consequently, harm reduction strategies taken up in policy and services struggle to accommodate pleasure, while a focus on danger and risk is inculcated. Often, this neglects or dismisses the subjective benefits of use, and instead tries to encourage an inclination for risk aversion. As I have argued, the emphasis on risk aversion is better replaced by a critical exploration of risk engagement. Here, I have taken up youth treatment services as a productive site to explore how young people engage with and negotiate risk. Working against the neglect of pleasure in alcohol and other drug using narratives, I argue that better recognition of the multiple experiences and understandings of consumption bring with it opportunities to develop enabling environments.

By using a case study approach to interrogate attitudes and notions of alcohol and other drug use, I traced the progression of ideas and experiences that challenge negative discourses of consumption practices. When contemplating their use, some participants offered 'narratives of decline' to explain negative effects they experienced. However, in doing so, they expose how alcohol and other drug use is intimately bound up in the social and physical environments in which it occurs. Further, the decline is often punctured by integral elements of pleasure, socialisation and productivity. Assumptions concerning use as intrinsically and inevitably harmful fail to account for individual agency and positive aspects of consumption. The making of the 'addict' in these settings is, in part, a product of negative societal approaches to alcohol and other drug use. Further, as seen in the previous chapter, young people are constituted as risk taking and vulnerable, lacking volition and the ability to make the right health choices. While young people often take up and embody these dominant approaches, they also offer elements that challenge these narratives.

Differences in participant narratives also reflect differences in the service's approaches. Service A adopts a recovery-oriented approach, actively employs and attributes addiction labels, and requires clients to abstain from alcohol and other drug use. In turn, Daryn and Chloe (both from Service A) described how alcohol and other drugs 'tore my life to pieces' and how 'trying to get' and 'getting' 'clean' are key (recovery-oriented) goals. These comments reflect a negativity in approaches to alcohol and other drugs and consumers. In contrast, Service B focuses on harm reduction, 'complex psychosocial problems' and 'substance dependence', and abstinence is not a requirement of Service B engagement. The effects of these approaches are reflected in Esther and Maurice's narratives. For Esther, her anticipated future substance use is intended to be enjoyable and infrequent 'maybe occasionally, once every six months', while Maurice states that any use needs to be done 'respectfully toward yourself'. Both comments reflect a harm reduction approach, not an abstinence-based one. These different approaches have key implications for the social and physical environments in which these young people engage. For instance, if services deny the possibility of safe and pleasurable consumption (e.g., Service A), or focus too much on multiple kinds of 'problems' (e.g., Service B) then this risks creating environments that facilitate mismatches between service and client goals and priorities.

Chapter Six: Making meanings of addiction in youth treatment engagement

How do treatment settings work to produce particular understandings of addiction? My review of the literature (Chapter Two) presented contemporary arguments that addiction is not a static illness or affliction, but a progressively developed assemblage of ideas with multiple meanings. Literature that takes service engagement as a focal point helps us in questioning the ways that the 'user' and the 'addict' are produced in treatment settings. In this chapter, I explore how particular ideas about addiction are produced in treatment settings.

Some studies have explored alcohol and other drug treatment settings. Indeed, in Chapter Two, I explored the Australian sociological literature on experiences of treatment. My review revealed efforts to contextualise service experience within individual and social histories and conditions (see in particular Fraser & valentine, 2008; MacLean et al., 2013; Salter & Breckenridge, 2014), but scholarship on marginalised young people's experiences of treatment, especially work exploring how drug harms and notions of 'addiction' are produced, is especially wanting. In the same chapter, I reviewed the literature on alcohol and other drug policy analysis. Some of this literature argues that evidence-based policy is a product of multiple influences (Ritter, 2009, 2011; Ritter & Bammer, 2010) and that policy attempts to quantify alcohol and other drug treatment outcomes create unintended effects (Moore & Fraser, 2013). I explored these ideas in Chapter Four, analysing national and state alcohol and other drug policies. As argued in Chapter Four, policy is itself shaping the environments in which young people consume alcohol and other drugs. When policy denies pleasure, or does not come to grips with the world that young people inhabit, then it fails to acknowledge priorities and needs specific to young people. This failure can actually create a risk environment. The effects of this are also experienced in treatment settings, where not only national and state policy have effects, but so too do service policy and practice.

In this chapter I aim to illustrate how notions of addiction are produced and experienced in the treatment setting. Drawing on the literature, the risk environment theory presented earlier in this thesis, and interviews conducted with young people, this chapter is divided into two parts. First I present two key approaches to treatment, loosely divisible into abstinence-oriented and harm reduction-oriented. In the second part, I draw on my interviews to explore how young people conceptualise addiction through their treatment experiences. The ways in which young people in this study spoke about addiction were frequently linked to their treatment experiences. This suggests that ideas of addiction are, at least in part, shaped by

treatment experiences and service approaches. As in Chapter Five, I utilise a case study approach, conducted at two levels. At the first level, the services from which I recruited research participants form the first case study approach. As noted earlier, the two services offer quite different approaches, although this is not to suggest that they are opposites, or that they have no commonalities. At the second level, four participant interviews are analysed minutely. This focus on a few individual accounts aims to create the space to understand and address participants as whole people, with complex, irreducibly complex stories (Pienaar et al., 2015), the details and texture of which are inseparable from their significance for the analysis. My case study approach was explained in detail in Chapter Three. In brief, it involves drawing on cases at two levels: recruitment from two services, and in-depth analysis of a few individual accounts. Based on the explanations offered by participants, and how they respond to services, I conclude that addiction is actively learnt rather than diagnosed through treatment engagement.

Two key approaches to treatment

In Chapters Three and Five, I introduced Service A and Service B. In Chapter Three, I gave key descriptors of them, including when and why the services were initiated, how they obtain funding, and their aims and missions. In Chapter Five, with the support of participant interviews, I examined the aims of these services and young people's understandings of alcohol and other drug use, as shaped by their service experiences. In this chapter (Six), the notion of addiction is examined. Service A and Service B approach alcohol and other drug use and addiction in ways that both overlap with and contradict each other. Some services find it helpful to articulate a clear and targeted 'problem'; others try to avoid imposing labels and categories on their clients. Service A, an abstinence-based service, adopts the first approach. Service B, which emphasises the multiplicity of concerns that young people may experience, adopts the second approach. Instead of offering a singular modality that targets alcohol and other drug-related problems, some services (such as Service B) respond to a broad range of concerns without automatically labelling or categorising their clients.

Service A identifies itself as a recovery-oriented service and incorporates the 12-step model into its day programs. This model has an extensive history and is especially concerned with notions of free will and volition. Temperance movement scholars argue that it denoted addiction by internal conflict and desire, and associated it with loss of individual will and autonomy (Levine, 1985). Later studies (e.g., Keane, 2002; Sedgwick, 1993; Summerson

Carr, 2011) investigated how this notion of free will is central to 12-step approaches to addiction. Established in 1935, Alcoholics Anonymous is a 'self-help' group whose 12 steps are well publicised (Sussman, 2010). From this stemmed numerous other groups, including Narcotics Anonymous, that were designed to target particular 'addictions'. Published in 2011, Summerson Carr's influential book *Scripting Addiction* explores how people engaged with the 12-step model produce particular alcohol and other drug use narratives. In this respect, the '12 Steps of Recovery' produce addiction: working through the steps teaches participants in the program to learn about themselves. Although this model is often understood as a form of the disease model of addiction, Keane (2002) notes that Alcoholics Anonymous theory (12 steps) also encompasses Christian revivalism, temperance doctrine, and other ideas about habit and behaviour modification. It is a particular disease concept very different from the medical one (Weinberg, 2002). The 12-step program works to construct addiction as the 'antithesis of freedom' (Keane, 2002, p. 3). Treatment requires participants to focus on themselves and their peers as a means of keeping themselves and each other 'clean' and 'sober' (Sussman, 2010). One participant interviewed for my project, Chloe (F, 24, alcohol and methamphetamines, Service A), explained her pattern of service contact as follows:

> Umm, five days a week I have to be here, until you become a senior and then you can start looking for work and come in here two days a week. Umm, but I guess, like, I have to do two drug screens a week and remain drug and alcohol free on and off the premises. Umm, I have to attend NA [Narcotics Anonymous] meetings four times a week, but I do one everyday anyway and that's part of the program and just everything. Like they take us to swimming, to the gym, and I guess it's just about trying to change my behaviours and stuff while I'm in here and, you know, just being like attending groups and stuff like that … so like we have a personal development group where we look at, like, some behaviours like co-dependency. We look at, like, assertiveness, just all those kind of personal development things to help ourselves. We do a relapse prevention group and a Steps group and then we do a team-building group.

In this interview extract, surveillance (twice-weekly drug screens) and behaviour modification form key aspects of this service's treatment modality. For Chloe, treatment focuses on individual behaviour change and regulation. She also mentions differences in

experiences for people who have achieved senior status. Another client of the same service, Daryn (M, 22, alcohol and methamphetamine, Service A), explained that:

> Umm, so like there's a questionnaire sheet. They ask you what your qualities might be, like I think it's three of your strengths, three of your weaknesses, umm, what else is there? There's a couple of questions along those lines and then there's like three scenarios, so there's one that's like if another resident is using [alcohol and other drugs], like, how would you approach them to support them to come and tell staff about it, sort of thing. Yeah, it's just like scenarios of how you're role-modelling skills, sort of thing. Yeah, so you do that worksheet and you bring that in and then you have an interview with two other senior residents and one worker where they'll ask you, like, more questions off another worksheet, just to see how you sort of instant respond to, like, different things.

As Daryn subsequently elaborated, achieving 'senior' status brings certain privileges (such as being allowed to work and drive a car) not available to 'junior' clients. Further, senior status can be rescinded if any service rules are broken (such as consuming alcohol and other drugs). The detailed program, comprehensive rules and client categorisation demonstrate a clear treatment modality centred on individual behaviour modification and regulation.

In stark contrast, Services B adopts a very different approach to the treatment of alcohol and other drug-related problems. Indeed, while Service A participants spoke about their treatment purpose and processes with precision and clarity, clients of Service B demonstrated a degree of vagueness when questioned about treatment aims and processes. Service B has a broader remit than Service A. While Service A emphasises the treatment of a single unified problem, addiction, Service B responds to multiple problems that young people may experience. Further, it aims to take a patient-centred, consumer driven approach concerned primarily with welfare. Although there may appear some vagueness in their comments, the participants recruited from Service B reproduce the idea that their treatment should be patient-centred. Unlike at Service A, the goals and steps are not imposed, but once they are identified, the service works to support clients in achieving them.

In terms of service experiences, instead of indicating their exposure to particular treatment modalities, Service B participants often referred to particular areas or aspects of their lives

the service supported them with. alcohol and other drug issues did not figure in Marty's (M, 20, heroin, cannabis, Service B) explanation about what stimulated his initial service contact.

> I don't really remember, it was like friends were talking about it and they were like, 'this, that, this, that, they can give you a shower and some food and what not' and I ended up going there and have been coming here since.

However, more recently, Marty has engaged in counselling at Service B. Marty describes Service B as 'helpful' and 'good' and elaborates that:

> They'll sort of sit back and let you do everything in your own time and that's sort of what makes them good. Like they'll sit back and just be like 'you can do this, this, this and this, however, those are your options, come to us when you're ready, we're not going to actually force you to do anything'.

These comments suggest that Service B encourages clients to exercise choice over their treatment experiences. Lee (F, 21, heroin, Service B), who had been engaged with Service B's day program, and was in its detox facility at the time of the interview, made similar comments about her experiences:

> You know umm, if I wanted to go to detox, they got me into a lot of detoxes. They got me into the rehabs, they helped me fill out forms. They've got the day program, music program, t-shirt making, cooking, I just wanted support you know, and they really gave me that. Not just even be a worker, just be a family. I don't know, 'don't take to me like a client, like for once, just speak to me like normal' you know. Umm and I think that's like I really needed that. Like they spoke to me like very, she [a worker] was very motherly, and [another worker] was very fatherly and I think that's why I really – I mean I was up and down, but I think that's kind of why I listened and I stayed …

Lee describes Service B as supporting her to make her own choices about her service engagement and treatment. Further, her comments about workers being 'motherly' and 'fatherly' suggest a particular kind of relationship that she has developed with specific workers. When questioned about this relationship, Lee explained that, 'they'll give me pep

talks, because you build a relationship with them … they really showed me that they care kind of thing'. For Lee, being engaged with Service B is based on forming relationships and support to make choices. Lee's comments suggest that client experiences differ directly based on service modality, and that clients benefit differently from different approaches.

In this section I have introduced the different approaches to treatment adopted by two Victorian youth alcohol and other drug services. While participants from Service A described a highly structured and targeted treatment program, participants from Service B described a more fluid approach to responding to alcohol and other drug use. Participants from Service B described many of their interactions with workers as casual discussions that emphasised exploring options and did not necessarily centre on alcohol and other drug use. However, in both instances, these approaches do indicate the kinds of problems that young people are understood to have. Service A's recovery-oriented approach and 12-step model positions young people as experiencing a single and unified problem: addiction. Service B provides a more open approach to treatment options, and is responsive to multiple problems. The implications of these approaches and the different conceptualisations of addiction that accompany them are discussed in the second part of this chapter.

What is the problem? Young people's understandings of addiction

As in the last chapter, here I utilise a case study approach to explore young people's understandings of the concept of addiction. I analyse the ways in which the young people in my study constitute the 'addiction problem'; in other words, the kinds of problems that addiction is said to be. Despite the common use of this term in Australia, defining addiction is not straightforward, and attempts to do so can oversimplify it as a single unified reality (Pienaar et al., 2015). Dominant approaches to addiction that present it as a set of clearly definable behaviours are complicated by the accounts of the problems identified by young alcohol and other drug consumers in this study (also see Fraser et al., 2014). In my analysis of the interviews I conducted, three key themes emerged in accounts of the 'addiction problem': control, physical sickness, and mental/emotional disorder. To investigate each, I focus on four of my interviews. I then draw conclusions from the analysis.

Moira: 'Addiction is a disease of your thinking'

Moira's approach is my first example of how services and dominant discourses work to shape understandings of addiction. At the time of the interview, Moira was 19 and part of Service

A's recovery program. She had also been treated for an eating disorder and taken part in a different rehabilitation program that followed 12-step teachings. When asked about the nature of addiction, Moira (F, 19, methamphetamine) expressed some confusion.

> I, I don't know. Like I don't know how to really explain it because, so many people get into my head about it. Because, like, to be honest, I actually, um, really struggle with it, with believing that ... like, I just thought I had a drug problem. And that I was addicted to drugs. But coming into recovery, into [Service A], and into the fellowship and stuff, and rehab, like, I've learnt ... well they tell me that its my thinking. That it's the way I … like I wouldn't use drugs if it wasn't for the way I thought.

These comments suggest that although Moira began with a particular understanding of what constitutes a drug problem or addiction, her experiences with services have reshaped her options. She is now asked to see herself as experiencing a problematic mental state. This approach identifies the individual as the site of the problem and encourages people to conceive themselves as addicts, a particular kind of person apart from normality. For Moira, service engagement has shaped what she thinks of addiction, and also how she sees herself.

> So, like, I believe that addiction is, is not just like yeah you get addicted to things but it's, addiction is a disease of your thinking. Like a disease of, the way, the way I think. The way my head works, the way that my head will tell me about myself and about, um, yes stuff like that. And then I resort to these things as a feel … to feel good or an escape.

When Moira explains that addiction is not simply that 'you get addicted to things', she offers a comparison with what she previously understood addiction to be. In earlier comments, Moira explained that she had experienced an eating disorder and said that her 'anorexia would be, would come under addiction'. This suggests that prior to service engagement she considered her problem to be a straightforward addiction caused by drug use, or else her status as a 'restrictor' (the practice of restricting calorie intake). However, as part of her service engagement, her understanding of addiction and herself underwent dramatic change. Framing addiction as a mental disorder encourages people to envision themselves as the problem. This resonates with the 12-step model. Although Service A is 'recovery oriented', it also presents addiction as an enduring individual problem. In this instance, Moira's

comments position the problem as one of internal weakness or disease, an inability to cope or deal with challenging situations, uncontrolled thoughts and escapism. Also noted previously, research has highlighted how this kind of treatment modality works to produce 'positive identity change' and in doing so responsibilises the individual and creates recovery identities (e.g., Fomiatti et al., 2017). However, she also explains that addiction is a disease. While scholars have argued that the notion of 'addiction as a disease' can work to mitigate individual responsibility (Keane, 2002), in this instance Moira maintains negative self-conceptions while also adopting elements of this particular disease model.

Oliver: 'I need something in me at all times, otherwise I can't survive'

Oliver (M, 21, alcohol and methamphetamines) is another participant recruited from Service A. Like Moira, he drew strong connections between what he had learnt through his service engagement and his ideas of addiction. Oliver was 21 years old when interviewed and had attended several rehabilitation facilities over the preceding two years. At the time of the interview, Oliver was engaged with Service A for the second time, after being ejected from the service for consuming illicit substances. His second contact with Service A had lasted eight months and he was 'looking at moving on soon'. He stated he wanted to remain abstinent, move out of supported care (provided by Service A) and 'eventually find a rewarding career'. He mentioned that this could involve becoming an alcohol and other drug worker. Indeed, several of the participants from Service A mentioned this potential career pathway and many of the staff had previously been engaged with Service A as clients. When asked to describe what he thought of addiction, Oliver explained that it had multiple aspects to it:

> So physical, mental and spiritual. I think that is what I've learnt anyway. So addiction physical [is] like the cravings and the sweats and that sort of stuff. Mental is the obsession, like always obsessing about it, and the spiritual: what was the spiritual? I forgot that, but yeah, so like addiction for me is like – the difference between me and someone else who's not addicted or not in addiction, like when I pick up [purchase drugs], I can't stop. I need something in me at all times otherwise I can't survive. Or I think I can't survive.

Oliver's comments raise several important points. Firstly, for him, addiction has three key aspects – the physical, mental and spiritual. Despite these key aspects, his comments suggest that he identifies addiction in himself through the presence of compulsion alone. Later he also elaborated that, although the 12 steps aim to achieve recovery, 'you are never recovered, you are always just recovering'. Further, he understands people with addiction as discernibly different from those without.

> I learnt that through NA, but they also do a lot of that stuff in here [Service A]. Yeah, so, I guess they've all got their own views… No, it's pretty much the same views, like that's just what they sort of teach us in here as well. […] So, you actually work through the twelve steps and so it's like just sort of discovering who you are, and how you behave, and all your behaviour patterns, and also who you have harmed, and how you can make amends to them.

These comments indicate that some aspects of Oliver's approach to addiction stems from his service contact. Also, his description of the service's teachings provides some insight into how the 'addict' is characterised. From Oliver's perspective, addiction is characterised by particular behaviours that require attention and change, while the addict is described as someone who causes harms to the self and others. Yet Oliver also offered insights that contradicted this initial perspective. For instance, when asked why he thinks addiction happens, he said:

> I believe mostly genetics. So, it's in my family and a lot of people that I see around in rehabs and stuff, it's always in their family. […] I had like mum, alcoholic, dad, alcoholic, mum abusing prescriptions, my brother always drinking, my dad's side of the family using heroin, choof [cannabis] everywhere. Like, it was just everywhere for me. So, I sort of was bound to get it.

Although Oliver specifies genetics as the key causal factor for addiction, his further comments discuss the social context in which he was exposed to alcohol and other drug use, and his final statement implicitly alludes to addiction as a medical disease (something people 'get'). He also added that: 'like, it also could be past trauma, people wanting to get away from their past and stuff by using drugs. A lot of people use drugs to escape'. Oliver initially cites addiction as comprising physical, mental and spiritual elements, and then further

elaborates to include compulsion, genetics, medical discourse, social context and experiences of trauma as all bound up in the experience of addiction. Despite an extensive list, absent is any recognition of the various forms of structural inequality and its effects. In this instance, how does his experiences of marginalisation (or specific issues such as poverty) contribute to other experiences such as alienation, trauma and alcohol and other drug issues?

Oliver's descriptions highlight the complexity of the addiction problem. While he cites an approach to addiction learnt through his service contact and engagement with the 12-step model, his own account does not fit their neatly simplistic formulae. For him, addiction is a problem of compulsion, related to trauma, driven in part by exposure, that causes physical, mental and spiritual disorder. However, in identifying addiction, even in such complex terms, Oliver's perspective leads toward a particular conceptualisation of the addict. For him, the addict is different from the non-addict, requiring behavioural changes and needing to make amends to others he/she has hurt. Further, when discussing abstinence-based goals, Oliver frequently employed the term 'clean', suggesting that people who use drugs are dirty. He also stated that abstaining from consumption would enable him to be in 'recovery', but he will never be wholly 'recovered'. According to these parameters, Oliver perceives himself as an addict (with all its implications) who will always be an addict, irrespective of whether he uses alcohol and other drugs again.

In this section, I examined two cases of Service A participants' explanations of addiction. Participants connected experiences of mental and emotional disorder, loss of control and sickness/withdrawal to the addiction problem, and linked all these issues to 12-step philosophy and protocols. It is clear that treatment services play a key role in shaping young people's notion of addiction. Government policy, as explored in Chapter Four, positions alcohol and other drugs as harmful to everyone, not just those who consume them. In these policies, treatment is a means of enabling people to recover from dependence and is presented as facilitating individual change. As noted in Chapter Three, Rhodes (2002) is critical of this focus on individual behaviour change as it offers a 'context free' approach (p. 86). These policies create a risk environment in which young people operate. In these policies, young people are exceptionally vulnerable to harm and unable to make the 'right' life choices. These highly prescriptive ideas about treatment and youth fail to account for any purposeful or pleasurable alcohol and other drug use. Further, they ignore the ways in which young people engage in their environments and negotiate their ways through their

experiences. It is also apparent that these notions actively shape young people's self-conceptions. Often this entails responsiblising people for poor choices and individual failings while simultaneously working to set them apart from 'normal' and 'healthy' body ideals. In the next two case studies I examine accounts offered by participants in Service B.

Marty: 'I'd schiz out if I didn't have it. I couldn't really quit it'

For Marty (M, 20, heroin, cannabis, Service B), along with many other participants in this study, the addiction problem was a combination of three elements – mental disorder, physical illness and loss of control. I met Marty at Service B's day program, which he had attended for six years. During this time, he had experienced unstable housing and homelessness. Marty described himself as having an addiction problem (related to cannabis), framing it as one of mental disorder:

> Because it got to the point where I'd schiz out if I didn't have it. I couldn't really quit it. I'd always be smoking it, whereas everything else, if I didn't have it, I'd be like 'yeah, cool whatever, I'll just wait until I have it next, whenever that happens'. Whereas with weed, I'd actually have a mental breakdown if I didn't have it.

Although Marty cites mental disorder as an effect of his addiction, he also claims that he 'couldn't really quit it'. Many studies have taken loss of control in alcohol and other drug use narratives as an object of study and inquiry. As Keane (2002, p. 3) explains, arguments about addiction as restricting autonomous choice are contestable and are unable to provide a reliable guide for what constitutes addictive actions. However, Marty also recognises that, for other people, addiction could comprise physical sickness (such as withdrawals) along with a mental disorder.

> There are sort of two sides to it, like, there's the actual physical addiction. Like, say for heroin and stuff, how you'll get dope sick if you don't have it. But then there's also like the mental addiction.

References to sickness and withdrawal invoke common binaries used to differentiate the healthy body and the addict. This discourse of addiction as characterised by withdrawal, compulsion and triggers plays a role in generating particular kinds of subjects. While Marty considers sickness part of the addiction problem, his further comments also offer insights into

how some addict bodies are framed as uncaring, and others as in control and agential. In talking about this, Marty employed the stigmatising term ‘junkie’.

> *Researcher: You also mentioned the word ‘junkie’ before. Can you tell me a little bit about what that means or what you understand that to be?*
>
> Marty: Just the people who have sort of lost control of their addiction, and just let go of themselves, and get really dirty, and don’t really care anymore.
>
> *Researcher: And you said, ‘lost control of their addiction’, does that mean that people can have an addiction and still be in control of it?*
>
> Marty: Yeah, to a degree. Like I’ve had mates that although they are heavily addicted to both ice and heroin, they’ll only use enough so that they don’t get sick. Whereas you’ll get other people that will use just as much as they can with no concerns for, like, the next day after, or getting dope sick, or anything like that.

According to Marty, when experiencing addiction, some people negotiate their use and can exercise control. Marty’s comments explain how people balance and negotiate risks of health and productivity in the drug using narratives. The addict as an irrational drug-using subject, often conceived in the disease model of addiction, fails to account for instances where people exercise choice and agency. Marty’s views here share something of Service B’s approach. Marty explains that although Service B will try to ‘help better you’, its person-centred approach means that the workers are not ‘going to actually force you to do anything’. Instead, Marty recalls, workers presented him with options (such as techniques to reduce use and services available including detox and rehabilitation). By providing clients with options, Service B challenges notions of reduced agency and actively encourages young people to make choices about their alcohol and other drug use and treatment engagement. Simultaneously, Service B encourages people to actively shape the environments they engage in by making them safer.

Lee: ‘It's hard when you’re on the outside’

Lee came into contact with workers from Service B when she was in juvenile detention, aged 15 years. She was attending Service B’s detox facility when I interviewed her. Lee described

workers from Service B as ‘like family, you know, they are the only family I have’. When asked what interested her about being in the study, Lee [F, 21, heroin] offered insight into what she thought of the addiction problem:

> We just need a voice kind of thing. We need to speak out and yeah obviously not a lot of addicts can do that … it's hard when you’re on the outside.

For Lee, the addiction problem is one of sickness, marginalisation and oppression; yet, she explained that she had experienced many of these issues throughout her life. As a child she experienced physical and mental abuse from her single parent, was exposed to abuse and oppression through foster care, and engaged in sex work as a minor. What role do negative conceptualisations of addiction play in justifying and responsiblising these experiences? As Karasaki et al. (2013) note, ‘to acknowledge the agency of addicts risks implying that they are at fault for freely engaging in activities considered morally and legally wrong in contemporary neo-liberal society’ (p. 8). Acknowledging the agency and control of ‘addicts’ carries implications for accountability. However, it also responsibilises individuals for how they are marginalised and oppressed. Alcohol and other drug users, sometimes conceived of as addicts, are often held up as examples of departure from normality. For Lee, her explanation of addiction draws on this conceptualisation of abnormality and expresses addiction as an opposing state to wholeness and wellness. In talking about her ideas of addiction, Lee refers to experiences and feelings of withdrawals:

> I think addiction, it all goes to run into normality, like you just want to feel normal. Not normal like every, so you’re not sick. I think that’s what addiction is: when you wake up and you’re fucking so sick because your body is lacking. It lacks something. You’re not one hundred per cent without this whatever it is, heroin, ice, and then once you have it, all these flu symptoms, all this stuff goes away. That’s when you’re addicted because your body’s telling you, ‘fuck like I can’t live without. I’m not going to get up, I can’t eat without this thing’, so it’s not a hundred per cent ...

The notion of ‘being 100%’ is an idealised version of normality. Similarly, those labelled addicts are often conceived of in terms of the ‘Other’ (Huggins, 2006). In analysing the embodied effects of anti-drug campaigns, Huggins (2006) notes that ‘the power of the image of the injecting drug user is critical to establishing the absolute violation of self and the

social' (p. 174). This powerful image, alongside Lee's explanations of her experiences, provides yet another example of how preconceived ideas about alcohol and other drug use work to produce particular subjects and subjectivities. For Lee, the sickness she experienced operates in two ways. First, it offers her a defining symptom, a way of determining her self-attribution of addiction. Second, it helps her to identify what she considers to be the problem. Many people experience sickness and poor health not related to alcohol and other drug use. However, for Lee, the sickness she experienced is attributed to the negative and oppressive state of addiction. In explaining her understanding of addiction, Lee draws distinctions between types of sickness. Society responds to cold and flu sufferers with medical attention and limited stigma. Although she also experiences 'flu symptoms', to her these symptoms are indicative of a failing (and addicted) body.

Notably, along with counselling and detox, Lee was receiving pharmacotherapy treatment in the form of Suboxone. Suboxone is one of two formulations of buprenorphine available to opioid pharmacotherapy consumers in Victoria (Harm Reduction Victoria, 2017). On multiple occasions throughout the interview, Lee cited her Suboxone use and her need to have ready access to it. When talking about being engaged with Secure Welfare Services[16] (prior to turning 18), Lee explained that 'every time I got out, I went back because […] they'll have Suboxone for me, which you know, [will mean] I won't be too sick'. Also, when discussing her current service engagement, Lee explained that 'obviously I go to the chemist every day, because I'm the only one here that's on heroin and needs Suboxone'. Further, Lee was diagnosed with hepatitis C when she was 17 years old. Her experiences in attempting to access treatment (including regular appointments with medical professionals and fortnightly blood testing) may have contributed to her sense of her sick and unhealthy body, and its relationship to addiction. In making these comments, I do not intend to understate or dismiss Lee's lived experience of sickness. Instead, I am attempting to delineate the connections that encourage people to see themselves as sick, as opposed to seeing themselves as a person experiencing sickness, or even as someone whose differences are not tolerated by society.

[16] Secure Welfare Services (SWS) is a form of government intervention for people aged 10 to 17 years who 'are at a substantial and immediate risk of harm' (SGV, 2017). SWS aims to remove young people from situations where they are exposed to risks of harm and provide 'protection services'. In doing so, young people may be placed in a 'secure facility' as a result of: 'an administrative decision for children subject to a family reunification order, a care by Secretary order or a long-term care order or via judicial order on an interim accommodation order' (SGV, 2017). In short, young people are not able to resist such placement, nor are they able to influence the duration of their placement.

In previous chapters, I introduced Service B as a harm reduction service which envisages addiction as a 'chronic and relapsing condition' and aims to help young people with 'complex psychosocial problems'. Further, the aims of this service suggest that it conceptualises alcohol and other drug problems and addiction as inherently linked to social isolation. This vulnerability is reiterated consistently throughout Australian and Victorian policy, and is also reflected in Lee's comments. Evidently these is a degree of consistency between policy, services and clients' understandings of vulnerability. However, absent from all of these accounts is how social structures work to facilitate vulnerability. Clearly, policy does not work to empower young people. However, Lee's recollections of her experiences with Service B suggests an alternative approach. Similarly, other Service B participants refer to their service experiences as being inclusive and empowering. Yet notwithstanding these tensions, as the previous chapter demonstrates, alcohol and other drug use and addiction are often still conceived in relation to decline and disadvantage. These points help to highlight conflict between types of environments (such as policy, physical and social). Although both Service A and Service B respond to Australian and Victorian policy, the way they enact treatment in their own physical and social settings produce distinctly different risk environments.

Conclusions

The concept of addiction is central to my research. Attributing this term to young people actively shapes how they see themselves and respond to their environments. Especially when addiction is understood as an enduring problem, this works to pigeonhole and label young people who may be experiencing a range of temporary and changing issues, not necessarily a product of or related to alcohol and other drug use. Addiction is seen to be a continually contested topic. Much of the scholarship that I draw on acknowledges the socially contingent nature of addiction. However, the youth treatment services from which this study's participants were recruited operate under a very different set of understandings. Notwithstanding the extensive range of approaches to addiction, they can be loosely divided into two broad categories of addiction conceptualisation: enduring or temporary.

As the cases discussed above show, participants in this study adopted both concepts of addiction. Perhaps unsurprisingly, young people engaged with Service A and its 12-step model considered addiction to be an enduring problem. Further, they identified the problem

as something that resides within them, an individual flaw. Although many aspects of their explanations of addiction resonate with the 'addiction as a disease' construct, as Keane (2002) aptly notes, fellowship teachings and their approaches to addiction are also encumbered by Christian revivalism, temperance doctrine and other ideas about habit and behaviour modification. Participants' references to changing 'the way I think' work to demonstrate how addiction has been learnt, not diagnosed through treatment engagement. Yet, despite efforts to change thought processes, or focus on 'behaviour patterns', for the clients of Service A addiction was an enduring condition which cannot be recovered from, but only continually addressed through the teachings of the 12 steps.

For those engaged with Service B, different approaches to addiction were evident. Participants recruited from this service described addiction as both an enduring and a temporary problem. Different explanations drew on biological, psychological and social elements that helped to define the addiction problem. While Service A participants voiced a clear account of their understanding of addiction, participants from Service B often showed less clarity, more subtle shading and more conflicting ideas. However, across all services and in almost all instances, the addiction problem encompassed issues of mental and emotional disorder, loss of control and physical sickness or withdrawal. Irrespective of whether participants understood addiction as an enduring or temporary problem, these three themes were present in accounts from participants in both services. The identification of these problems of alcohol and other drug use and addiction were consistent across treatment experiences. These problems are consistent with issues raised in policy documents, explored in Chapter Four, showing that these pathologising and negative expectations weave their way through policy and service discourse. What is unclear, however, is the extent to which young people are able to resist or even escape these constructs. My findings suggest that young people do take up these pathologising and negative expectations, however, I only interviewed young people actively engaged in services. More research that explores previous or interrupted service contact may yield a richer diversity of accounts.

Young people balance, negotiate and engage with ideas of mental and emotional disorder, loss of control and physical sickness or withdrawal and make changes accordingly, such as through staging consumption, deliberately engaging in particular environments or seeking resources and support from services. However, in many instances, they also reject or mitigate these experiences. Further, services operate in a broader environment in which young

people's ideas about alcohol and other drug use and addiction are developed and shaped. Applying Rhodes' risk environment framework to this study challenges perceptions that alcohol and other drug use and addiction are problems located within the individual, reflective solely of individual failings. Moreover, it gives primacy to context and alcohol and other drug use settings, and the services which offer treatment for alcohol and other drug problems can be conceived of as risk environments. As Rhodes (2002) notes, public health approaches often view harm as determined by individual action and focus on individual behaviour change. In turn, I argue that while youth treatment services often work to encourage individual behaviour change, they ignore the obstacles young people face in doing so. This moves away from a 'context free' approach (Rhodes, 2002, p. 86) and utilises a risk environment framework to explore how structural influences shape risks, harm and obstacles in young people's lives. As noted in my exploration of how policy produces a set of ideas about alcohol and other drug use, addiction, treatment, marginalisation and youth (Chapter Four), it is important to acknowledge how these ideas, alongside service experiences, work to shape and develop the risk environments in which young people operate. Using a case study approach enabled me to explore in-depth how young people take up, accommodate and reject the set ideas promulgated in Australian policy and service discourse and shed light on how young people understand their environments. Unfortunately, all too often, negative conceptualisations about alcohol and other drug use, addiction, and marginalised youth work to produce risk environments and facilitate further marginalisation and experiences of harm.

Chapter Seven: Conclusions

In this research, I achieved my key objectives – to learn how marginalised young people in contact with alcohol and other drug services understand their alcohol and other drug use and addiction, and provide future direction for service provision to marginalised young users. Addressing these objectives necessitated an exploration of the extent to which, and the various ways in which, marginalised young users take up, resist and/or accommodate the discourse of addiction that they encounter in their interaction with services. I also succeeded in presenting a critical analysis of policies and practices operating in the alcohol and other drug treatment setting as they relate to young people. Drawing on key policy documents and in-depth qualitative interviews with marginalised young people, my findings offer a new approach to understanding risk and harm and raise questions about the fit between young people's views and priorities and the aims and practices of services.

My project makes four key contributions to the field. Firstly, it provides new knowledge about how marginalised young people understand alcohol and other drug use and addiction. Secondly, it shows how Australian policy and services frame alcohol and other drug use and addiction. Thirdly , it illustrates how marginalised young Australian alcohol and other drug users take up, resist and/or accommodate the discourses of 'addiction' that they encounter in their interaction with services. Lastly, it applies, for the first time, a risk environment framework in an Australian study of young people's understandings of alcohol and other drug use and addiction and their engagement with services, thereby generating new insights for service providers, policy makers and researchers.

The main findings of this thesis are:

1. Marginalised young people are constituted in policy as being especially vulnerable, predisposed to taking risks and unable to make the 'right' choices, irrespective of their individual situations. Not only is policy unable to account for individual situations, but in presenting a set account of particular groups it can shape young people's understandings of themselves through pigeonholing them into rigid categories. Here, the question arises: if young people are incapable of making informed life choices, at what age does this change? Discounting young people's ability to make choices actively works to isolate them from other groups which policy deems capable. I would argue that, in suggesting that young people are unable to make the 'right' choices, policy encourages others to ignore and therefore leave underutilised young people's

ability or option to choose. This is especially pertinent when examining experiences with entities such as youth services, MMT (or similar) providers, and SWS, which regard marginalised young people as incapable of making important decisions concerning their interactions with them. However, it is important to note that the extent to which choices are restricted depends on the service; some services do actively engage young people in making decisions concerning their service interaction.

2. Young people's alcohol and other drug use is presented in policy and service discourse as a significant area of concern. Social context and pleasure are ignored, with all use conceived as harmful. However, participant narratives challenge such straightforward accounts, highlighting how use is often purposeful and intricately connected to social and physical environments. Participants spoke both positively and negatively about their use, and some saw it as part of their future lives. Service A adopted an abstinence-based approach, and so too did its clients. Similarly, Service B adopted a harm reduction approach, and so too did its clients. This suggests that service approaches hold considerable sway, not just for current experiences, but also for future practices. The extent to which participants chose and persisted with services that fit in with their own approaches is unclear, but some did express support for the approach with which they were engaged.

3. Addiction emerges as a social construct with multiple meanings and implications. The policies analysed in Chapter Four present a highly stigmatising approach to addiction, attributing to affected people lost volition, low health concern and lack of internal resources such as resilience. In the services these ideas are elaborated, and both Service A and Service B present addiction as an enduring condition. The most concerning aspect of this is that it can encourage young people to identify and categorise themselves as 'addicts', and experience with it all the ensuing stigmatisation. Importantly, however, according to my participants, alcohol and other drug problems were only one of the reasons that prompted service engagement. While I do not intend to dismiss participants' experiences of alcohol and other drug problems, my research points to a greater need to recognise and respond to a wide range of problems that young people experience. By moving away from focusing on alcohol and other drug problems and addiction, we can better acknowledge how they

work to develop safe using environments and other alternatives. Labelling young people with addiction, and following the tendency in policy to privilege one-way causal models, creates risk environments in which young people may struggle to engage and are denied the ability to negotiate their own engagement.

Implications and contributions to the field

I began this thesis by noting that the term 'addiction' is heavily contested. Often replaced in Australian medical contexts with the putatively less stigmatising term 'dependence', here I have used it as an umbrella term. This allowed critical investigation of the ways it, and associated notions and terms (such as dependence), are constituted and operate in Australian society, culture and politics. As discussed in Chapter Two, the literature review on which this thesis is grounded, addiction has recently been described as at once socially constituted and materially real (Fraser et al., 2014). Contrary to medical discourses that envision addiction as a straightforward biological fact, sociological research recognises that it is socially constituted over time, and that we can study this constitution. Indeed, that is exactly what I endeavoured to do in this project. When young people encounter, or take up, an idea of addiction in coming into contact with a service, this can reshape their experiences of their use – not merely address them. Service contact, in other words, forms an important part of the construction process. This opens up the question of whether this process is optimal for young people, whether and to what extent it relates to other aspects of experience for them, and what kinds of construction might work best to help marginalised young people account for their circumstances, access the resources they need, and identify and fulfil their aspirations.

However, simply asking marginalised young people about their treatment experiences and ideas about alcohol and other drug use and addiction is not enough. First, it is important to acknowledge, as I did in Chapter Three, that the qualitative interview and its subsequent transcript are sites of performance and not simply representative of individual 'lived experience' (Mazzei, 2013, p. 737). Further, if we see the interview as an 'assemblage' (p. 735) then we can also acknowledge that meaning is made in the interview. In looking at 'how' and 'why' marginalised young alcohol and other drug consumers formulate their perspectives on and understandings of their use, and addiction in general, it is necessary to also note the role the researcher plays in this process. As this would suggest, the researcher and her theoretical orientation necessarily predispose and shape data collection and methods of analysis. Indeed, theory and method are inherently connected and rely on each other. In

this project, I do not seek absolute answers or some form of coherent 'solution' to treatment. Instead, the theory I use enables me to consider how different young people experience treatment and what implications this could have for future practices. From the outset, I explored this way of thinking and learning about marginalised young people's alcohol and other drug use and notions of addiction. In doing this, I adopted a poststructuralist approach, and, as elaborated in Chapter Three, addressed a gap in the literature by exploring young people's perceptions of harms and problems through a risk environment framework. A poststructuralist account disputes Enlightenment assumptions of a single reality and essential truth. Similarly, perceptions of, and engagement with the notion of risk cannot be treated simplistically as an exercise in negotiating objective, commonly agreed harms. As Mary Douglas explained (2013), the term 'risk' traditionally had both negative and positive connotations. Notions of risk and harm that circulate in policies and practices are embedded in preconceptions and investments, from which particular types of subjects are made. In the policies analysed in Chapter Four, the marginalised young drug-using subject epitomises the antithesis of the healthy liberal citizen. Safe social drinking is reserved for the well-controlled and rational adult thinker, while marginalised young consumers are linked to crime, trauma, poor health and a loss of volition. As seen in Chapters Five and Six, some participants accepted these representations, others accommodated them, and others still rejected them.

The risk environment approach used in the thesis (Rhodes, 2002, 2009) allowed me to identify environments as producers of harm and recognise the structural forces that shape harm and risk. In particular, in this thesis, the policies that govern service provision are conceived of as key to risk environments. They help constitute, not respond to, harm. This approach allowed me to consider how structural forces are accommodated or challenged in user narratives. Further, this approach allowed me to ask questions about enabling environments (Moore & Dietze, 2005), and to consider how and whether particular policies and the efforts made to implement them in services help constitute risk environments or safe environments. In Chapter Three, I suggested that in calculating risk, we create and attribute risk in a process of blame, and this operates to constitute and distribute personal liability. In attributing risk, we blame people for not being more risk averse. If people (in my work, marginalised young people) do not take the necessary steps to actively avoid risk, they become negligent and liable. With this as a basis, Rhode's risk environment framework enables researchers to explore both how people engage with risk, and how risk environments operate. In Chapters Four, Five and Six I explored how the policy, physical and social aspects

that govern service provision are themselves part of the environments in which young people consume alcohol and other drugs. In instances where these deny pleasure, or neglect the worlds young people inhabit, they fail to acknowledge priorities and needs specific to young people. This failure creates a risk environment and further shapes the risks of the young people engaged in it.

The risk environment approach has helped me to untangle the complexities of the circumstances in which young marginalised alcohol and other drug users survive, the construction of their ideas about alcohol and other drugs (both positive and negative), and to understand how their thinking and practices are affected by structural dynamics. Importantly, a theory that helps us understand risk as environmental also opens up investigation of safety and pleasure as environmental. In particular, drawing on the approaches of the two services studied in this project, we see how different understandings of addiction and treatment work to shape and determine treatment goals. At a basic level, harm reduction and abstinence-based approaches create different understandings of safety and pleasure. While not as openly negative about drug use as abstinence-based approaches, harm reduction approaches taken up in policy and services often struggle to accommodate pleasure. Frequently, this neglects or denies the subjective benefits of use, and instead tries to encourage an inclination to risk aversion. As I have argued, the emphasis on risk aversion is better replaced by a critical exploration of risk engagement. This theory reminds us that outcomes of alcohol and other drug use are not simply the effects of individual characters or conduct, but a culmination of influences that all need to be considered together (Farrugia, 2014). While this thesis focuses on how environments can work to produce and be instigators of harm, my aim is not to minimise or sideline the short and long-term harms that can be experienced in the context of alcohol and other drug use. The analysis does however, raise questions about whether excessive, disproportionate or insufficiently nuanced attention to these harms, and the stigma that can accompany this attention, serve to further problematise particular alcohol and other drug consumers and indirectly increase harm.

The participant interviews I conducted were extremely useful when exploring my two key themes (alcohol and other drug use and addiction). As seen in Chapter Five, some participants offered narratives of ‘decline’ to explain negative effects of their use (Pienaar et al., 2017). In my interviews, negative explanations of alcohol and other drug use often emerged early; comments that challenged these ideas and presented accounts of pleasure and

sociality came later. The narratives highlight how experiences of alcohol and other drug use is intimately bound up in and influenced by the social and physical environments in which they occur. Further, assumptions concerning use as intrinsically and inevitably harmful fail to account for individual agency and positive aspects of consumption. Services operate in an environment in which young people's ideas about alcohol and other drug use and addiction are developed and shaped, but this does not mean young people are easily moulded. They continue to engage critically with the gap between their own and services' perspectives and aims. Applying Rhodes' risk environment framework to this study challenges perceptions that alcohol and other drug use and addiction are problems located within the individual, reflective of individual failings. It gives primacy to context and settings, and as a result the services which offer treatment for alcohol and other drug problems can be conceived of as risk environments. Moreover, it raises questions about the effectiveness (and the risk of irrelevance) when services do not attend to young people's priorities and perspectives.

What is missing

In presenting the key findings, significance and implications of this research, it is also important to clearly identify its limitations. There are some things that this project did not aim to achieve, and never could. For instance, while thousands of Victorians access treatment services annually, by contrast, this project conducted 19 qualitative interviews, all with marginalised young people. I make no claims about representativeness with respect to the findings presented in this thesis (to do so, more research needs to be conducted). Instead, I sought to conduct an in-depth exploration of some experiences, the aim being to raise questions about links between subjective experiences and priorities, service aims and approaches and broader government policy. Additionally, the theoretical approach on which this research rests calls for researchers to acknowledge that data cannot be seen as a straightforward window into reality. Instead, the data I present aims to highlight the multiplicity of experiences and understandings that young people have of their alcohol and other drug use and the environments in which they operate.

Secondly, there are some limitations in the representativeness of the demographics of this research. Comprehensive records about young people's demographics and their alcohol and other drug service engagement are unavailable. Therefore, it is not possible to determine how close the demographics of the participants in this study are to the broader demographics of young people who engage with alcohol and other drug treatment services. For instance,

although attempts were made to recruit an equal number of young men and women, in the end I recruited eleven men and eight women. Similar issues also arose when considering other demographics, such as ethnicity and sexuality. Some participants, having spent many years in foster care, could not nominate a meaningful ethnicity, or, where a formal nomination was known to them, its relevance to their lives was sometimes questioned.

Bridging the gaps

In this thesis, I do not aim to provide a step-by-step guide to the provision of better alcohol and other drug treatment to marginalised young Victorians. Moreover, I not wish to dismiss or discount any of the benefits participants experienced in engaging with treatment and other services. Many of the participants spoke positively about their service experiences and identified important aspects in which Service A or B had supported them. However, I do argue that more attention should be paid to how particular ideas about alcohol and other drug use and addiction are, in part, made through service contact experiences. Similarly, I identify the ways these ideas are presented in policy documents, and the direct negative implications of them. Using a risk environment framework is simply one of many ways that these ideas can be explored. It was especially useful for my research, as it helped to uncover how particular ideas presented in policy and practice work constitute the environments and risks that young people encounter.

By drawing on in-depth qualitative interviews, I was able to consider how mismatches arise between service and client understandings of alcohol and other drug use or addiction, and the goals and priorities of service engagement. Policy approaches to young people as inherently vulnerable, predisposed to taking risks and incapable of making the 'right' life choices are tested and challenged in this thesis. Young people's narratives concerning their alcohol and other drug use and understandings of addiction suggest that policy's apparently straightforward account insufficiently explains the nuances of their experiences. In Chapter Five I presented participants' accounts that challenged ideas of alcohol and other drug use as connected to decline. Although some participants offered initial examples of decline, their ensuing explanations often described a far more complex trajectory. Further, in Chapter Six, I described conflicting accounts of the topic of addiction. While in all cases there is reason to suggest that young people's understandings of addiction are shaped by their service experiences, there are also grounds to conclude that understandings of addiction are far more complex than dominant accounts allow. By this I mean that alcohol and other drug addiction

should not be perceived as a direct consequence of consumption, or that people face an increased likelihood based on demographic characteristics. Instead, my analysis highlights the fluid and socially contingent way that addiction is understood and evolves across time and space. These mismatches help to highlight the socially contingent nature of addiction, and also the importance of keeping individuals' stories 'whole' (Pienaar et al., 2015). The case study approach allowed me to explore how ideas of addiction change over time, even within a single interview. It is important to acknowledge these mismatches and consider how they shape experience and individual subjectivity. However, it is especially important to note discrepancies between client and service understandings of the goals and priorities for service engagement. In this project I touched upon this issue and identified it as a key area of interest; I encourage researchers to consider it worthy of further investigation.

In closing, I suggest that we move beyond relying on 'addiction' or 'dependence' to describe alcohol and other drug problems. While their meanings constantly evolve, they remains unable to reflect the diversity of experiences, and instead facilitate stigma and reduce people to simple categories. Marginalised young people face a range of challenges and problems and as such engage in an array of risk environments. If we acknowledge that to be a young person does not equate to being a vulnerable risk taker, then opportunities instead of limitations may arise. While young people may negotiate their way through risk environments, they will also be able to negotiate through safer ones.

References

Addiction Centre. (2017). Addiction Center - 12 Step Programs. [online] Available at: https://www.addictioncenter.com/treatment/12-step-programs/ [Accessed 12 Dec. 2017].

Aitken, C., Moore, D., Higgs, P., Kelsall, J., & Kerger, M. (2002). The impact of a police crackdown on a street drug scene: evidence from the street. *International Journal of Drug Policy, 13,* 193-202.

Aitken, C., Lloyd, B. & Dietze, P. (2017). Victorian Drug Trends 2016. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trends Series No.166. Sydney, National Drug and Alcohol Research Centre, UNSW, Australia.

Al-Anon Family Group Headquarters. (1996). Al-Anon's Twelve Steps. [online] Available at: https://al-anon.org/the-legacies/the-twelve-steps/ [Accessed 12 Dec. 2017]

alcoholthinkagain. (2014), Alcohol statistics. [online] Available at: http://alcoholthinkagain.com.au/Resources/Alcohol-Use-Statistics [Accessed 2 Jan. 2018].

Australian Bureau of Statistics. (2013). 4125.0 - Gender Indicators: Australia Jan. 2013. [online] Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4125.0main+features3150Jan%2013 [Accessed 2 Jan. 2018].

Australian Drug Foundation. (2013). Alcohol. Available [online] at: www.shop.adf.org.au *pamphlet was obtained directly from Service B (2016).

Australian Institute of Health and Welfare (AIHW). (2014). Australia's Health. Australian Government, Canberra. [online] Available at: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548150 [Accessed 29 Dec. 2014].

Australian Institute of Health and Welfare (AIHW). (2016a). Alcohol and other drug treatment services in Australia 2014-15. [online] Available at: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2014-15/contents/table-of-contents [Accessed 20 Sep. 2017].

Australian Institute of Health and Welfare (AIHW). (2016b). Alcohol and other drug treatment services in Australia 2014-15: State and Territory summaries. [online] Available at: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2014-15/contents/table-of-contents [Accessed 20 Sep. 2017].

Australian Institute of Health and Welfare (AIHW). (2017a). National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW). (2017b). Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) 2014-15. [online] Available at: http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/aodts-nmds-2014-15/ [Accessed 9 May 2017].

Australians Together (2018). The Stolen Generations. [online] Available at: https://www.australianstogether.org.au/discover/australian-history/stolen-generations [Accessed 8 July 2018].

Babbie, E. (2010). *The practice of social research.* 12th edn. Belmont, CA: Wadsworth.

Bacchi, C. (2009). *Analysing policy: What's the problem represented to be?* Sydney: Pearson Education.

Barad, K. (2003). Posthumanist performativity: Toward an understanding of how matter comes to matter. *Signs: Journal of women in culture and society, 28*(3), 801-831.

Berg, B. (1995). *Qualitative research methods for the social sciences.* 2nd edn. Boston, MA: Allyn Bacon.

Best, W, D., & I Lubman, D. (2016). Friends matter but so does their substance use: The impact of social networks on substance use, offending and wellbeing among young people attending specialist alcohol and drug treatment services. *Drugs: Education, Prevention and Policy*, *24*(1), 111-117.

Bourgois, P. (2003). *In search of respect: Selling crack in El Barrio.* United Kingdom: Cambridge University Press.

Brodie, J., & Redfield, M. (2002). *High anxieties: Cultural studies in addiction,* Berkeley, CA: University of California Press.

Brown, R., & Gregg, M. (2012). The pedagogy of regret: Facebook, binge drinking and young women. *Continuum: Journal of Media and Cultural Studies, 26*(3), 357-369.

Bruun, A. (2015). *The Victorian Youth Alcohol and Other Drug Service System: A vision realised.* Melbourne: Youth Support and Advocacy Service.

Buchanan, I. (2010). *A dictionary of critical theory.* Oxford: Oxford University Press.

Carnwarth, T., & Smith, I. (2002). Ripping and running: Drug use and crime. In T. Carnwarth & I. Smith (Eds.), *Heroin Century* (pp. 119-136). London: Routledge.

Coleman, L. M., & Cater, S. M. (2005). A qualitative study of the relationship between alcohol consumption and risky sex in adolescents. *Archives of Sexual Behavior, 34*(6), 649-661.

Crowe, K. (2016). Secure Welfare Services: Risk, security and rights of vulnerable young people in Victoria, Australia. *Youth Justice, 16*(3), 263-279.

Cruwys, T., Berry, H., Cassells, R., Duncan, A., O'Brien, L., Sage, B., & D'Souza, G. (2013). *Marginalised Australians: Characteristics and predictors of exit over ten years 2001-10*. Canberra: University of Canberra.

Dennis, F. (2016). Encountering "triggers": drug–body–world entanglements of injecting drug use. *Contemporary Drug Problems, 43*(2), 126-141.

Department of Health & Human Services (DHHS). (2015a). About youth-specific alcohol and other drug treatment services. [online] Available at: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-services-for-young-people [Accessed 12 Jul. 2016].

Department of Health & Human Services (DHHS). (2015b). Alcohol and other drug service guidelines. [online] Available at: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-service-guidelines [Accessed 12 Jul. 2016].

Department of Health & Human Services (DHHS). (2015c). Alcohol and other drug workforce policy. [online] Available at: https://www2.health.vic.gov.au/alcohol-and-drugs/alcohol-and-other-drug-workforce/aod-workforce-policy [Accessed 12 Jul. 2016].

Department of Health and Human Services (DHHS). (2017a). Program guidelines: Alcohol and other drugs Part 2: Program and service specifications. [online] Available at: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-program-guidelines [Accessed 13 Nov. 2017].

Department of Health and Human Services (DHHS). (2017b). Services for young people. [online] Available at: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-services-for-young-people [Accessed 11 Sep. 17].

Department of Health. (2012). *Victorian alcohol and other drug treatment principles: Consultation paper*. Melbourne: Victorian Government Department of Health.

Department of Health. (2013a). Service specifications for the delivery of selected alcohol and other drug treatment service, State of Victoria. [online] Available at: http://www.health.vic.gov.au/aod/sectorreform.htm [Accessed 13 Nov. 2017].

Department of Health. (2013b). *Victorian alcohol and drug treatment principles*. Melbourne: Victorian Government.

Derrida, J. (2002). The rhetoric of drugs. In A. Alexander & M. S. Roberts (Eds.), *High Culture: Reflections on Addiction and Modernity* [pp. 19-43]. SUNY Press.

Dilkes-Frayne, E. (2014). Tracing the "event" of drug use: "Context" and the coproduction of a night out on MDMA. *Contemporary Drug Problems, 41*(3), 445-479.

Dixon, D., & Coffin, P. (1999). Zero tolerance policing of illegal drug markets. *Drug and Alcohol Review, 18*(4), 477-486.

Douglas, M. (2013). *Risk and blame*. London: Routledge.

Duff, C. (2005). Party drugs and party people: Examining the "normalisation" of recreational drug use in Melbourne, Australia. *International Journal of Drug Policy, 16*(3), 161-170.

Duff, C. (2007). Towards a theory of drug use contexts: Space, embodiment and practice. *Addiction Research and Theory, 15*(5), 503-519.

Duff, C. (2008). The pleasure in context. *International Journal of Drug Policy, 19*(5), 384-392.

Duff, C. (2010). Enabling places and enabling resources: New directions for harm reduction research and practice. *Drug and Alcohol Review, 29*(3), 337-344.

Duff, C. (2011). Reassembling (social) contexts: New directions for a sociology of drugs. *International Journal of Drug Policy, 22*, 404-406.

Duff, C. (2012). Accounting for context: Exploring the role of objects and spaces in the consumption of alcohol and other drugs. *Social & Cultural Geography, 13*(2), 145-159.

Dwyer, R., & Fraser, S. (2016). Making addictions in standardised screening and diagnostic tools. *Health Sociology Review, 25*(3), 223-239.

Ennett, S., Bauman, K., Hussong, A., Faris, R., Foshee, V., & Cai, L. (2006). The peer context of adolescent substance use: Findings from social network analysis. *Journal of Research on Adolescence, 16*(2), 159-186.

Farrugia, A. (2014). Assembling the dominant accounts of youth drug use in Australian harm reduction drug education. *International Journal of Drug Policy, 25*, 663-672.

Farrugia, A.C., & Fraser, S. (2015). Science and scepticism: Drug information, young men and counterpublic health. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. 21*(6), 595-615.

Farrugia, A.C., & Fraser, S. (2017). Young brains at risk: Co-constituting youth and addiction in neuroscience-informed Australian drug education. *Biosocieties, 12*(4), 588-610.

Fomiatti, R., Moore, D., & Fraser, S. (2017). Interpellating recovery: The politics of "identity" in recovery-focused treatment. *International Journal of Drug Policy, 44*, 174-182.

Foster, K., & Spencer, D. (2013). "It's just a social thing": Drug use, friendship and borderwork among marginalised young people. *International Journal of Drug Policy, 24*, 223-230.

Foster, M., Nathan, S., & Ferry, M. (2010). The experience of drug-dependent adolescents in a therapeutic community. *Drug and Alcohol Review, 29*(5), 531-539.

Fraser, S. (2015). Articulating addiction in alcohol and other drug policy: A multiverse of habits, *International Journal of Drug Policy, 31*, 6-14.

Fraser, S., & Moore, D. (Eds.). (2011). *The Drug Effect: Health, Crime and Society*. Melbourne: Cambridge University Press.

Fraser, S., & Seear, K. (2011). *Making disease, making citizens: The politics of hepatitis C.* Aldershot: Ashgate.

Fraser, S., & valentine, K. (2008). *Substance and Substitution: Methadone Subjects in Liberal Societies.* New York: Palgrave Macmillan.

Fraser, S., Moore, D., & Keane, H. (2014). *Habits: Remaking Addiction*. London. Palgrave Macmillian.

Fry, M. L. (2010). Countering consumption in a culture of intoxication. *Journal of Marketing Management, 26*(13-14), 1279-1294.

Goodwin, I., Griffin, C., Lyons, A., McCreanor, T., & Moewaka Barnes, H. (2016). Precarious popularity: Facebook drinking photos, the attention economy, and the regime of the branded self. *Social Media + Society, 2*(1), 1-13.

Gourlay, J., Ricciardelli, L., & Ridge, D. (2005). Users' experiences of heroin and methadone treatment. *Substance Use & Misuse: Taylor and Francis, 40*, 1875-1882.

Granfield, R., & Reinarman, C. (Eds.). (2014). *Expanding addiction: Critical essays*. London: Routledge.

Green, R. (2012). *An ethnographic study of recreational drug use and identity management among a network of electronic dance music enthusiasts in Perth, Western Australia* (Ph.D. thesis). Perth, Curtin University.

Green, R., & Moore, D. (2009). “Kiddie drugs” and controlled pleasure: Recreational use of dexamphetamine in a social network of young Australians. *International Journal of Drug Policy*, *20*(5), 402-408.

Green, R., Mitchell, P., & Bruun, A. (2013). Bonds and bridges: perspectives of service-engaged young people on the value of relationships in addressing alcohol and other drug issues. *Journal of Youth Studies, 16*(4), 421-440.

Griffin, C., Bengry-Howell, A., Hackley, C., Mistral, W., & Szmigin, I. (2009). “Every time I do it I absolutely annihilate myself”: Loss of (self-)consciousness and loss of memory in young people’s drinking narratives. *Sociology, 43*(3), 457-476.

Guise, J. M., & Gill, J. S. (2007). “Binge drinking? It's good, it's harmless fun”: a discourse analysis of accounts of female undergraduate drinking in Scotland. *Health Education Research, 22(*6), 895-906.

Hadland, S., Marshal, B., Kerr, T., Qi, J., Montaner, J., & Wood, E. (2010). Depressive symptoms and patterns of drug use among street youth. *Journal of Adolescent Health, 48*, 585-590.

Harm Reduction Victoria. (2017). Pharmacotherapy: Buprenorphine Naloxone (Suboxone). [online] Available at: http://hrvic.org.au/pharmacotherapy/pharmocatherapy-available/buprenorphine-naloxone-suboxone/ [Accessed 12 Dec. 2017].

Harris, M., Rhodes, T., & Martin, A. (2013). Taming systems to create enabling environments for HCV treatment: Negotiating trust in the drug and alcohol setting. *Social Science & Medicine, 83*, 19-26.

Hernandez, L., Leontini, R., & Harley, K. (2013). Alcohol, university students, and harm-minimization campaigns: "A fine line between a good night out and a nightmare". *Contemporary Drug Problems, 40*(2), 157-189.

Hitchens, C. (2010). *The ‘Other’ L word,* Vanity Fair. [online] Available at: https://www.vanityfair.com/culture/2010/01/hitchens-like-201001 [Accessed 4 Jan. 2018]

Huberman, M., & Miles, M. B. (2002). *The qualitative researcher's companion*. Thousand Oaks: Sage.

Huggins, R. (2006). The addict’s body: Embodiment, drug use, and representation in Vannini, P. (Eds.) (2016). *Body/embodiment: Symbolic interaction and the sociology of the body* pp. 165-180, Routledge.

Hughes, K. (2007). Migrating identities: The relational constitution of drug use and addiction. *Sociology of Health & Illness, 29*(5), 673-691.

Jäger, S. & Maier, F. (2009). Theoretical and methodological aspects of Foucauldian critical discourse analysis and dispositive analysis. In R. Wodak & M. Meyer (Eds.), *Methods for critical discourse analysis.* Sage. [online] Available at: http://sk.sagepub.com/books/methods-of-critical-discourse-analysis [Accessed 18 Aug. 2016].

Karasaki, M., Fraser, S., Moore, D., & Dietze, P. (2013). The place of volition in addiction: differing approaches and their implications for policy and service provision. *Drug and Alcohol Review, 32*(2), 195-204.

Keane, H. (2001). Public and private practices: Addiction autobiography and its contradictions. *Contemporary Drug Problems, 28*(4), 567-595.

Keane, H. (2002). *What's wrong with addiction?* Melbourne: Melbourne University Press.

Keane, H. (2009). Intoxication, harm and pleasure: An analysis of the Australian National Alcohol Strategy. *Critical Public Health, 19*(2), 135-142.

Keys, D., Mallet, S., & Rosenthal, D. (2006). Giving up on drugs: homeless young people and self-reported problematic drug use. *Contemporary Drug Problems, 33*(1), 63-98.

Koro-Ljungberg, M. (2008). Positivity in qualitative research: examples from the organized field of postmodernism/poststructuralism. *Qualitative Research, 8*(2), 217-236.

Kuntz, A. and Presnall. M. (2012). Wandering the tactical: From interview to intraview. *Qualitative Inquiry, 18*(9), 732 –744.

Lancaster, K. (2014). Social construction and the evidence-based drug policy endeavour. *International Journal of Drug Policy, 25*(5), 948-951.

Lancaster, K., & Ritter, A. (2014). Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010. *International Journal of Drug Policy, 25*(1), 81-87.

Lancaster, K., Santana, L., Madden, A., & Ritter, A. (2015). Stigma and subjectivities: Examining the textured relationship between lived experience and opinions about drug policy among people who inject drugs. *Drugs: Education, Prevention and Policy, 22*(3), 224-231.

Lankenau, S. (2006). On ketamine: In and out of the K hole. In Sanders, B. (Ed.), *Drugs, clubs and young people : Sociological and public health perspectives.* Aldershot: Ashgate Publishing.

Law, J. (2011). Collateral realities. In F. Dominguez Rubio & P. Baert (Eds.), *The politics of knowledge* (pp. 156-178), London: Routledge.

Leavy, J., Wood, L., Phillips, F., & Rosenbery, M. (2010). Try and try again: qualitative insights into adolescent smoking experimentation and notions of addiction. *Health Promotion Journal of Australia, 21*(3), 208-214.

Lenton, E,. & Fraser, S. (2016). Hepatitis C health promotion and the anomalous sexual subject. *Social Theory & Health, 14*(1), 44-65.

Levine, H. G. (1985). The discovery of addiction: Changing conceptions of habitual drunkenness in America. *Journal of Substance Abuse Treatment, 2*(1), 43-57.

Lindsay, J. (2009). Young Australians and the staging of intoxication and self-control. *Journal of Youth Studies, 12*(4), 371-384.

Loxley, W., Gray, D., Wilkinson, C., Chikritzhs, T., Midford, R., & Moore, D. (2005). Alcohol policy and harm reduction in Australia. *Drug and Alcohol Review, 24*, 559-568.

Mawson, E., Best, D., Beckwith, M., Dingle, G. A., & Lubman, D. I. (2015). Social identity, social networks and recovery capital in emerging adulthood: A pilot study. *Substance abuse treatment, prevention, and policy, 10*(1), 45.

MacLean, S. (2007). Global selves: Marginalised young people and aesthetic reflexivity in inhalant drug use. *Journal of Youth Studies, 10*(4), 399-418.

Maclean, S. (2008). Volatile bodies: Stories of corporeal pleasure and damage in marginalised young people's drug use. *International Journal of Drug Policy, 19*, 375-383.

MacLean, S. (2016). Alcohol and the constitution of friendship for young adults. *Sociology, 50*(1), 93-108.

MacLean, S. J., Kutin, J., Best, D., Bruun, A., & Green, R. (2014). Risk profiles for early adolescents who regularly use alcohol and other drugs compared with older youth. *Vulnerable Children and Youth Studies, 9*(1), 17-27.

Maclean, S., Bruun, A., & Mallett, S. (2013). "I've had a pretty tough life but that's not why I do this": Narratives of autonomy and control among alcohol and drug service-engaged early teenagers. *Journal of Youth Studies, 16*(2), 206-221.

Maher, L. (1997). *Sexed work: Gender, race, and resistance in a Brooklyn drug market.* Oxford University Press.

Mallet, S., Rosenthal, D., & Keys, D. (2005). Young people, drug use and family conflict: Pathways into homelessness. *Journal of Adolescence, 28*, 185-199.

Manderson, D. (2011). Possessed. In S. Fraser & D. Moore (Eds.), *The drug effect: Health, crime and society* (pp. 224-239). Melbourne: Cambridge University Press.

Manton, E., & Moore, D. (2016). Gender, intoxication and the developing brain: Problematisations of drinking among young adults in Australian alcohol policy. *International Journal of Drug Policy, 31*, 153-162.

Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (2nd edition). Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Margolis, S. (2002). Addiction and the ends of desire. In J. Brodie & M. Redfield (Eds.), *High anxieties: Cultural studies in addiction.* Berkeley*:* University of California Press.

Marrati, P. (2006). Time and affects: Deleuze on gender and sexual difference. *Australian Feminist Studies, 21(*51), 313-325.

Marshal, M. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-525.

Marshall, C., & Rossman, G. (2010). *Designing qualitative research.* Newbury Park, CA: Sage Publications.

Martin, A., & Stenner, P. (2004). Talking about drug use: What are we (and our participants) doing in qualitative research? *International Journal of Drug Policy, 15*, 395-405.

Marvasti, A. B. (2004). *What is qualitative research? Qualitative research in sociology.* London: Sage Publications.

Mawson, E., Best, D., Beckwith, M., Dingle, G. A., & Lubman, D. I. (2015). Social identity, social networks and recovery capital in emerging adulthood: A pilot study. *Substance Abuse Treatment, Prevention, and Policy*, *10(*45), 1-11.

Mayock, P. (2005). "Scripting" risk: Young people and the construction of drug journeys. *Drugs: Education, Prevention and Policy, 12*(5), 349-368.

Mazzei, L. (2013). A voice without organs: Interviewing in posthumanist research. *International Journal of Qualitative Studies in Education, 26*(6), 732-740.

Measham, F. (2008). The turning tides of intoxication: Young people's drinking in Britain in the 2000s. *Health Education & Behavior, 108*(3), 207-222.

Measham, F., & Brain, K. (2005). "Binge" drinking, British alcohol policy and the new culture of intoxication. *Crime, Media, Culture, 1*(3), 262-283.

Measham, F., Newcombe, R., & Parker, H. (1994). The normalization of recreational drug use amongst young people in North-West England. *British Journal of Sociology*, *45*(2), 287-312.

Melley, T. (2002). A terminal case. In J. Brodie & M. Redfield (Eds.), *High anxieties: Cultural studies in addiction.* Berkeley: University of California Press.

Meyers, T. (2013). *The clinic and elsewhere: Addiction, adolescents, and the afterlife of therapy.* London: University of Washington Press.

Midford, R., Acres, J., Lenton, S., Loxley, W., & Boots, K. (2002). Cops, drugs and the community: Establishing consultative harm reduction structures in two Western Australian locations. *International Journal of Drug Policy, 13*(3), 185-192.

Ministerial Council on Drug Strategy (MCDS). (2006). *National alcohol strategy 2006–2009.* Canberra: Commonwealth Government of Australia.

Ministerial Council on Drug Strategy (MCDS). (2011). *National drug strategy 2010–2015.* Canberra: Commonwealth Government of Australia.

Mol, A., & Law, J. (2002). *Complexities: An introduction.* Durham, NC: Duke University Press.

Moore, D. (2008). Erasing pleasure from public discourse on illicit drugs: On the creation and reproduction of an absence. *International Journal of Drug Policy, 19*(5), 353-358.

Moore, D., & Dietze, P. (2005). Enabling environments and the reduction of drug-related harm: Re-framing Australian policy and practice. *Drug and Alcohol Review*, *24*(3), 275-284.

Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science & Medicine, 62*(12), 3035-3047.

Moore, D., & Fraser, S. (2013). Producing the "problem" of addiction in drug treatment. *Qualitative Health Research, 23*(7), 916-923.

Moore, D., Fraser, S., Törrönen, J. & Eriksson Tinghög, M. (2015). Sameness and difference: Metaphor and politics in the constitution of addiction, social exclusion and gender in Australian and Swedish drug policy. *International Journal of Drug Policy, 26*(4), 420-428.

National Health and Medical Research Council (NHMRC). (2007). Australian Code for the Responsible Conduct of Research (updated March 2014). Canberra. Commonwealth of Australia.

National Health and Medical Research Council (NHMRC). (2009). Australian guidelines to reduce health risks from drinking alcohol. [online] Available at: https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf [Accessed 12 Jul. 2016].

Olsen, A. (2009). Consuming e: Ecstasy use and contemporary social life. *Contemporary Drug Problems, 36(*1-2), 175-191.

Orum, A., Feagin, J., & Sjoberg, G. (1991). The nature of the case study. In J. R. Feagin, A. M. Orum & G. Sjoberg (Eds.), *A case for the case study*. Chapel Hill, NC: UNC Press Books.

Oxford University Press. (2017). Oxford Dictionaries. [online] Available at: https://en.oxforddictionaries.com/definition/risk [Accessed 16 May 2017].

Parker, H. J., Aldridge, J., & Measham, F. (1998). *Illegal leisure: The normalization of adolescent recreational drug use*. New York, NY: Psychology Press.

Peele, S. (1990). Addiction as a cultural concept. *Annals of the New York Academy of Sciences, 602*(1), 205-220.

Peele, S., & Brodsky, A. (1975). Love and Addiction. [online] Available at: http://www.peele.net/lib/laa.html [Accessed 6 Jul. 2017].

Pennay, A. (2012). Carnal pleasures and grotesque bodies: Regulating the body during a "big night out" of alcohol and party drug use. *Contemporary Drug Problems, 39*(3), 397-428.

Pienaar, K., Fraser, S., Kokanovic, R., Moore, D., Treloar, C., & Dunlop, A. (2015). New narratives, new selves: Complicating addiction in online alcohol and other drug resources. *Addiction Research & Theory, 23*(6), 499-509.

Pienaar, K., Moore, D., Fraser, S., Kokanovic, R., Treloar, C., & Dilkes-Frayne, E. (2016). Diffracting addicting binaries: An analysis of personal accounts of alcohol and other drug "addiction". *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*. pp. 1-19.

Pienaar, K., Dilkes-Frayne, E., Fraser, S., Kokanovic, R., Moore, D., Treloar, C., & Dunlop, A. (2017). *Experiences of alcohol and other drug addiction, dependence or habit in Australia: Findings and recommendations from a national qualitative study.* Perth: National Drug Research Institute, Curtin University.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal, 320,* 114-116.

Power, E. (2004). Toward understanding postmodern interview analysis: Interpreting the contradictory remarks of a research participant. *Qualitative Health Research, 14*, 858-865.

Preyde, M., & Adams, G. (2008). Foundations of addictive problems: Developmental, social and neurobiological factors. *Adolescent Addiction*, pp. 3-16.

Punch, K. (2014). *Introduction to social research: Quantitative and qualitative approaches* (3rd edn). London: Sage Publications.

Raikhel, E., & Garriott, W. (Eds.). (2013). *Addiction Trajectories.* Durham, NC: Duke University Press.

Rance, J., Treloar, C., Fraser, S., Bryant, J. & Rhodes, T. (2017). 'Don't think I'm going to leave you over it': Accounts of changing hepatitis C status among couples who inject drugs. *Drug and Alcohol Dependence, 173*, 78-84.

Reinarman, C. (2005). Addiction as accomplishment: The discursive construction of disease. *Addiction Research & Theory, 13*(4), 307-320.

Rhodes, T. (2002). The "risk environment": a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy, 13*, 85-94.

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy, 20*, 193-201.

Rhodes, T., & Coomber, R. (2010). Qualitative methods and theory in addictions research. In P. G. Miller, J. Strang & P. M. Miller (Eds.), *Addiction research methods* (pp. 59-78). Chichester: Wiley-Blackwell/Addiction Press.

Rhodes, T., Davis, M. & Judd, A. (2004). Hepatitis C and its risk management among drug injectors in London: Renewing harm reduction in the context of uncertainty. *Addiction, 99*(5), 621-633.

Rhodes, T., Harris, M., & Martin, A. (2013). Negotiating access to medical treatment and the making of patient citizenship: The case of hepatitis C treatment. *Sociology of Health and Illness, 35(*7), 1023-1044.

Rhodes, T., Singer, M., Bourgois, P., Friedman, S., & Strathdee, S. (2005). The social structural production of HIV risk among injecting drug users. *Social Science and Medicine 61*(5), 1062-1044.

Rich, M., & Ginsburg, K. R. (1999). The reason and rhyme of qualitative research: Why, when, and how to use qualitative methods in the study of adolescent health. *Journal of Adolescent Health, 25*(6), 371-378.

Ritter, A. (2009). How do drug policy makers access research evidence? *International Journal of Drug Policy*, *20*(1), 70-75.

Ritter, A. (2011). The role of research evidence in drug policy development in Australia. *Politička Misao, 45*(5), 141-156.

Ritter, A., & Bammer, G. (2010). Models of policy-making and their relevance for drug research. *Drug and Alcohol Review, 29*(4), 352-357.

Ritter, A., & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug and Alcohol Review, 25*(6), 611-624.

Ritter, A., Lancaster, K., Grech, K., & Reuter, P. (2011). *An assessment of illicit drug policy in Australia (1985 to 2010): Themes and trends.* National Drug and Alcohol Research Centre.

Room, R. (1976). Ambivalence as a sociological explanation: The case of cultural explanations of alcohol problems. *American Sociological Review, 41*(6), 1047-1065.

Room, R. (1986). Historical perspectives on the treatment to alcohol problems: Case studies in six societies. *Contemporary Drug Problems, 13*, 387-393.

Room, R. (2001). Intoxication and bad behaviour: Understanding cultural differences in the link. *Social Science and Medicine, 53*, 189-198.

Room, R. (2003). The cultural framing of addiction. *Janus Head*, *6*(2), 221-234.

Rosenthal, D., Mallet, S., Milburn, N., & Rotheram-Borus, M. (2008). Drug use among homeless young people in Los Angeles and Melbourne. *Journal of Adolescent Health, 43*, 296-305.

Salter, M., & Breckenridge, J. (2014). Women, trauma and substance abuse: Understanding the experiences of female survivors of childhood abuse in alcohol and drug treatment. *International Journal of Social Welfare, 23*, 165-173.

Sanders, B. (2006). Young people, clubs and drugs In B. Sanders (Ed.) *Drugs clubs and young people: Sociological and public health perspectives* (pp. 1-12). Aldershot: Ashgate Publishing.

Sarantakos, S. (2005). *Social research* (3rd edn.). New York: Palgrave Macmillan.

Savic, M., & Fomiatti, R. (2016). Producing "progress" through the implementation of outcome monitoring in alcohol and other drug treatment. *Contemporary Drug Problems, 43*(2), 169-187.

Sedgwick, E. K. (1993). *Tendencies*. Durham, NC: Duke University Press.

Severns, J. (2004). A sociohistorical view of addiction and alcoholism. *Janus Head, 7*(1), 149-166.

Siokou, C., Moore, D., & Lee, H. (2010). "Muzzas" and "old skool ravers": Ethnicity, drugs and the changing face of Melbourne's dance party/club scene. *Health Sociology Review, 19*(2), 192-204.

Smith, R. G., Jorna, P., Sweeney, J., & Fuller, G. (2014). *Counting the costs of crime in Australia: A 2011 estimate.* Research and Public Policy Series 120. Canberra: Australian Institute of Criminology.

State Government of Victoria (SGV). (2012). Reducing the alcohol and drug toll: Victoria's plan 2013-2017, Victorian Government. [online] Available at: https://www2.health.vic.gov.au/about/publications/researchandreports/Reducing-the-alcohol-and-drug-toll-Victorias-plan-2013-2017---Strategy [Accessed 17 Feb 2015].

Summerson Carr, E. (2011). *Scripting addiction: The politics of therapeutic talk and American sobriety*. New Jersey: Princeton University Press.

Sussman, S. (2010). A review of Alcoholics Anonymous/Narcotics Anonymous programs for teens. *Evaluation & the health professions*, *33*(1), 26-55.

Tellis, W. (1997). Application of a case study methodology. *The Qualitative Report, 3*(3), 1-19.

Topp, L. (2011). Suicide in Australia: Where do alcohol and other drugs fit in? *Of Substance: The National Magazine on Alcohol, Tobacco and Other Drugs*, *9(*1), 18-21.

Townshend, T. (2013). Youth, alcohol and place-based leisure behaviours: A study of two locations in England. *Social Science and Medicine*, *91*, 153-161.

Treloar, C., & Fraser, S. (2009). Hepatitis C treatment in pharmacotherapy services: Increasing treatment uptake needs a critical view. *Drug and Alcohol Review, 28*(4), 436-440.

valentine, K. (2009). Evidence, values and drug treatment policy. *Critical Social Policy, 29(*3), 443-464.

valentine, K & Fraser, S. (2008). Trauma, damage and pleasure: Rethinking problematic drug use. *International Journal of Drug Policy, 19*(5), 410-416.

Van der Poel, A., & Van de Mheen, D. (2006). Young people using crack and the process of marginalization. *Drugs: Education, Prevention and Policy, 13*(1), 45-59.

Weedon, C. (1997). *Feminist practice and poststructuralist theory* (2nd edn.). Oxford: Blackwell Publishing.

Weinberg, D. (2002). On the embodiment of addiction. *Body and Society, 8*(4), 1-19.

Weinberg, D. (2011). Sociological perspectives on addiction. *Sociology Compass, 5*(4), 298-310.

Williams. J. (2005). *Understanding poststructuralism.* Chesham: Acumen Publishing Limited.

Wilson, M., Saggers, S., & Wildy, H. (2013). Using narratives to understand progress in youth alcohol and other drug treatment. *Qualitative Research Journal, 13*(1), 114-131.

Woolgar, S. (2011). Where did all the provocation go? – reflections on the fate of Laboratory Life. STS Workshop at the European University of St Petersburg, Russia, 19th November 2011. [online] Available at: https://www.youtube.com/watch?v=gPDNptLkiyk [Accessed 8 Jan 2018].

Yap, M., Reavley, N., & Jorm, A. (2012). Young people's beliefs about the harmfulness of alcohol, cannabis and tobacco for mental disorders: Findings from two Australian national youth surveys. *Addiction, 107*(4), 838-847.

Zinberg, N. (1984). *Drug, set and setting.* New Haven, Yale University Press.

Appendix A – Recruitment Flyer

Are you aged between 16 and 24 and currently attending an AOD service?

If so, we would like to speak to you!

We are seeking people who have been part of counselling for alcohol and other drug use in the last six months.

Taking part in the study involves a confidential audio recorded interview of about one hour.

In return, **you will get a $40 voucher!**

The interview will take place in a location convenient to you!

This study wants to explore personal experiences and understandings of alcohol and other drug use and addiction among young people in contact with AOD services.

For additional information, or to participate in the study please contact Liz Normand on 0498 736 550 or at e.normand@postgrad.curtin.edu.au

Curtin University

NDRI national drug research institute

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Appendix B – Participant Information Statement

PARTICIPANT INFORMATION STATEMENT

HREC Project Number:	*5912*
Project Title:	*How do marginalised young people who are in contact with AOD services understand their alcohol and other drug use and 'addiction'?*
Principal Investigator:	*Professor Suzanne Fraser – Program Leader and ARC Future Fellow*
Student researcher:	*Ms Elizabeth Normand*
Version Number:	*2*
Version Date:	*24APR2015*

What is the project about?

- Little is known about the meanings marginalised young people give to their alcohol and other drug (AOD) use, and how social structures and environments (particularly AOD service contact) influence these meanings.
- The project will involve 20 in-depth interviews with young (16-24 years) AOD users who are in contact with AOD services, and a further 10 interviews with AOD service providers.
- It will examine how harms and risks (and benefits and safety) are constructed and attributed to young marginalised AOD users, and how these people respond.
- The findings will inform AOD services on how their approaches are received by the people they treat.

Who is doing the research?

- The research is being conducted by Curtin University staff and students. The results will be used as the basis for a Doctor of Philosophy thesis. The project is funded by the University.

Why am I being asked to take part and what will I have to do?

- The project will interview 20 young (16-24 year old) people. These people must have had either five counselling sessions or a week of rehabilitation for alcohol and other drug use in the last six months.
- The project aims to interview young people experiencing marginalisation. If you are experiencing social stigmatisation (e.g. are a single parent accessing welfare payments or, have a disability), early life disadvantage (e.g. parental unemployment, incomplete schooling), financial hardship (e.g. reliance on welfare, low income, high financial stress), poor health (e.g. chronic health problems, poor mental health, poor physical functioning) and social isolation (e.g. few social contacts, little social support, poor quality relationships) then we would like to speak to you.

- Participation involves a confidential interview of about one hour. We will make a digital audio recording of the interview so we can concentrate on what you have to say and not distract ourselves with taking notes. After the interview we will make a full written copy of the recording.
- The interview will take place in locations convenient to you such as parks, coffee shops, or meeting rooms at alcohol and other drug services.
- We will ask you questions about your current circumstances and your ideas about alcohol and other drug (AOD) use and addiction. We will also ask you about your own AOD use and practices, the goals you hope to achieve from your contact with AOD services, your understandings of service's objectives and relevance of these to your own situation. We will also ask what you think 'addiction' means.
- There will be no cost to you for taking part in this research. You will be reimbursed $40 (or equivalent in the form of a gift voucher for under 18 year olds) for participating.

Are there any benefits to being in the research project?

Aside from the reimbursement, there may be no direct benefit to you from participating in this research. Sometimes people appreciate the opportunity to discuss their opinions and feelings.

We expect the results of this research to:

- Enhance alcohol and other drug service approaches to the people they seek to treat
- Prevent alcohol and other drug harm
- Promote health
- Add to the knowledge we have about how people understand 'addiction'

Are there any risks, side-effects, discomforts or inconveniences associated with taking part in the research?

We have been careful to ensure that the questions in the interview do not cause you any distress. But, if you feel anxious about any of the questions you do not need to answer them. If the questions cause any concerns or upset you, we can refer you to a counsellor. Sometimes just thinking about alcohol and other drug use and 'addiction' can be upsetting. If you chose not to be in this research but feel distressed as a result of considering it then please contact Beyond Blue 1300 22 4636 or Lifeline 13 11 14. Both these services are free of charge to you.

There is a risk of the researcher receiving a subpoena and the need to disclose information to the authorities.

Who will have access to my information?

- The information collected in this research will be non-identifiable (anonymous). This means we will not collect individual names. No one, not even the research team, will be able to identify your information. Any information we collect and use during this research will be treated as confidential. The following people will have access to the anonymous information we collect: the research team and the Curtin University Ethics Committee.
- Electronic data will be password-protected and hard copy data (including audio tapes) will be in locked storage.

- The information we collect will be kept under secure conditions at Curtin University for a minimum of 7 years after publication or project completion, or the subject/s have reached 25 years of age, whichever is later, then destroyed. You have the right to access, and request correction of, your information in accordance with relevant privacy laws.
- The results of this research may be presented at conferences or published in professional journals and a PhD thesis. You will not be identified in any results published or presented.
- Although it will not be volunteered, information about illegal behaviour collected in the interview may be subject to court subpoenas.

Will you tell me the results of the research?

- As the research is confidential and your details will not be stored we will be unable to contact you directly to tell you the results of the study. However, a summary of the findings will be posted on our web site in 2017 (www.addictionconcepts.com)

Do I have to take part in the research project?

- Taking part in a research project is voluntary. You do not have to agree if you do not want to. If you decide to take part and then change your mind, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of any thing that needs to be done so you can withdraw safely. If you choose not to take part, or start and then stop the study, it will not affect your relationship with the University. If you choose to leave the study we will use any information collected unless you tell us not to.
- There is nothing unsafe about withdrawing from this project. Your access to the services will not be affected and your information will not be provided to the service.

What happens next and who can I contact about the research?

- If you have any questions about the research please contact Liz Normand on 0498 736 550 or at e.normand@postgrad.curtin.edu.au
- If you decide to take part in this research we will ask you to sign the consent form. By signing you are telling us that you understand what you have read and what has been discussed. Signing the consent form indicates that you agree to be in the research project and have your data used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

Ethics committee overseeing this project

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the Curtin University HREC. This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). If you have any concerns and/or complaints about the project, the way it is being conducted or your rights as a research participant, and would like to speak to someone independent of the project, please contact: The Curtin University Ethics Committee by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Appendix C – Participant Consent Form

CONSENT FORM

HREC Project Number:	*5912*
Project Title:	*How do marginalised young people who are in contact with AOD services understand their alcohol and other drug use and 'addiction'?*
Principal Investigator:	*Professor Suzanne Fraser – Program Leader and ARC Future Fellow*
Student researcher:	*Ms Elizabeth Normand*
Version Number:	*2*
Version Date:	*24APR2015*

- I have read the information statement listed above and I understand its contents.
- I believe I understand the purpose, extent and possible risks of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that this project has been approved by Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007) – updated March 2014.
- I understand I will receive a copy of this Information Statement and Consent Form.

Participant Name	
Participant Signature	
Date	

Declaration by researcher: I have supplied an Information Letter and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent and possible risks of their involvement in this project.

Researcher Name	
Researcher Signature	
Date	

Note: All parties signing the Consent Form must date their own signature.

Appendix D – Informed Consent Script

INFORMED CONSENT SCRIPT

Ok so I'll start off by telling you a bit about my project and what we are going to be doing here today. A bit over a year ago, I started a PhD and that involves me doing a research project. I was thinking about young people and their drug and alcohol use and I was interested in what the media says and how that affects the way society responds to young people who take drugs and drink alcohol. The media always seems so quick to point out all the bad things and I was thinking that it overlooks how young people themselves experience their drug and alcohol use and also their lives more generally. So for my research project I wanted to talk to young people and get their perspectives to help us understand what their experiences actually are. Also, the term 'addiction' is constantly used in media, like ads, film and tv, but it's not clear what the term addiction actually means and what other people think about it. So that will also be something that I'd like to talk to you about today.

Cool, so, there's a few more important things you need to know before we start.

[GIVE THEM SHEET] This information sheet explains everything about the study, what it aims to do, what's involved in being in the study, and also the potential risks and benefits to you of taking part.

You could read it through for yourself but it's probably easiest if I quickly tell you all the main points. You can also keep that copy to take away with you.

So, I'm a student with Curtin Uni and the results from this study will be used by me and other staff members from Curtin for the purpose of my PhD.

All up I'm aiming to interview 20 young people who have been either in rehab or counselling over the past 6 months, and who are experiencing some difficult life circumstances at the moment.

Taking part in the study involves doing an interview. This is completely confidential and should take about an hour. I will record the interview so I can concentrate on what you have to say and not be distracted by taking notes. I'll then transcribe the interview so I have a full written copy of the recording.

In the interview I'll ask you questions about your experiences with drinking and drug use and a bit about your contact with services . I'll also ask you about your ideas of addiction and there are also some questions about your current life circumstances

For taking part in the interview, you will get a $40 gift voucher to reimburse you for your time and costs. While there's no other direct benefit to you from participating in this research, sometimes people just like having the opportunity to discuss their opinions and feelings.

We hope the results of this study will help improve alcohol and drug services approaches to people they seek to treat and help improve health of people who use drugs and alcohol.

We've been careful to make sure that the questions in the interview don't cause you any distress. But, if you feel anxious about any of the questions you don't need to answer them. If the questions

cause you any concerns or upset you, I can refer you to a counsellor. Also, if you choose not to be in this research but feel distressed just from thinking about being part of the study then please contact Beyond Blue 1300 22 4636 or Lifeline 13 11 14. Both these services won't cost you anything to use.

Also I do need to tell you there's a potential risk of the researcher receiving a subpoena and having to disclose information to the authorities. What this means, is that the courts are able to ask for information that researchers collect and legally, they have to hand it over. But, It is very unlikely that this would ever happen and it has never happened to any of the researchers at the National Drug Research Institute where I'm doing my PhD. Also I won't be asking you to give me details on any specific illegal activities so it's unlikely that courts would be interested in the information I'll be collecting.

Okay, so the information I collect from you will all be anonymous – I won't record your name so you won't be able to be identified - and everything you say is confidential. The research team and the Curtin University Ethics Committee will have access to the anonymous information. The information I collect will be kept under secure conditions at Curtin University (hard copies locked in filing cabinets/electronic files protected by passwords) for a minimum of 7 years after I finish my project.

The results from this may be presented at conferences or published in professional journals and a PhD thesis. You will not be identified in any results published or presented. If I quote from your interviews, you will be given a fake name.

Because the research is confidential and I won't keep records of your personal details, we won't be able to contact you directly to tell you the results of the study. However, a summary of the findings will be posted on our web site in 2017 (www.addictionconcepts.com)

Taking part in a research project is voluntary. You don't have to agree if you don't want to. If you decide to take part and then change your mind, you can withdraw from the project. You don't have to give us a reason; just tell us that you want to stop. If you choose to leave the study we will use any information collected unless you tell us not to.

There is nothing unsafe about withdrawing from this project. Your access to the services won't be affected and your information won't be provided to the service.

On the sheet I give you it'll have my phone number and email so you can contact me if you have any questions after the interview.

And the final bit of information: This study has been approved by the ethics committee at Curtin Uni. This committee looks over research projects to make sure they're okay and that they treat participants with respect. If you have any concerns with me or the questions I ask, or the project itself you can contact the ethics committee to talk to them about it.

DO YOU HAVE ANY QUESTIONS OR IS THERE ANYTHING ELSE YOU WANT ME TO EXPLAIN?

Okay, so now I've finished giving you all the information about the study and what's involved, if you still want to go ahead, I'll ask you to sign a consent form. This just says that you understand the study and you agree to take part [When you go through this process, READ EVERY ITEM AND CHECK THEY UNDERSTAND BEFORE ASKING THEM TO SIGN]

Appendix E – Semi-structured Interview Guide

Semi-structured Interview Guide – Service Users

- All participants are asked the same questions;
- You don't have to answer any questions you don't want to;
- there are no right or wrong answers, I'm really interested in your experiences and opinions
- Everything is kept confidential and a range of strategies will be used to protect your identity if you are quoted;
- At the end we'll be asking a few demographics questions which we ask all participants in the study.

Okay, I'll start with asking if you could tell me a bit about what is was that interested you about being in this study?

Area 1. Personal AOD use and practices

Okay, so, as you know, in this study, I'm interested in learning about people's experiences and understandings of using drugs and drinking so I'd like to talk to you about your experiences.

We can start with drinking. Is that something that you do? Can you tell me about your day-to-day experiences drinking alcohol?

And what about taking drugs. is that something you do? Can you tell me about your day-to-day experiences taking drugs?

Area 2. Understandings of service contact

Okay, I'd like to turn now to your experiences with services. I'll start with this service?

Can you tell me about what has brought you to this service?

- Is this something you feel you want help with?
- *[if participant expresses a concern or specific problem]* Do you feel like this service can help you with this? Can you tell me a bit more about that?
- Can you tell me about your experiences at this service? What does using this service involve?
- How long have you been in contact with this service?
- *[If counselling]*, how many visits have you had over the past six months?

What do you think the aims of this service are? What do you think it is trying to do for the people who come to the service?

- Do you feel like the service is helping you with the things that are important to you, the things you would like help with?
- Are there any things you would like help with that the service isn't helping you with. Can you tell me a bit more about that?

Have you had any other experiences with alcohol and drug services? Can you tell me about that?

- Types, when
- How many times have you used services?
- What have been your experiences with accessing services. Good. Bad. Both? Can you give me some examples.
- Do you feel like services are helping you with the things that are important to you, the things you would like help with?
- Are there any things you would like help with that the service isn't helping you with (what)?
- Are there any services they offer that you feel you don't need or that you would like to see replaced with something else?

[If used different services]. **In your experiences are there any differences between these services in how they go about helping you?** Can you give me some examples.

Has being in contact with services changed your experiences with your drug use or drinking? In what ways?

Area 3. Ideas about AOD use and addiction

As I said before, in this study, we're also interested in people's ideas and understandings of addiction?

Can you describe to me what you think addiction is?

- Is addiction an idea or a term that means something to you? Can you tell me a bit more about that?
- *[if addiction meaningless]* Do you think people can experience problems with their alcohol or drug use? How would you describe these problems?
- Why do you think addiction happens? (substances, personality, genetics)
- Can people take drugs or drink without becoming addicted?
- What about the idea of saying someone is an 'addict'. What do you think about that? Can you tell me a bit more about that?
- How do you know if you or someone is addicted?
- Do other people you know have different opinions on addiction. Can you tell me a bit more about that.

So we've spoken a bit about your ideas of addiction, I'd like to talk now a bit about that and your own experiences.

Is addiction a word you would use to describe your own experiences with alcohol or drugs? Can you tell me a bit more about that?

- What did you think you were addicted to?
- Were you taking any other drugs or alcohol at the time? How did you work out what it was that you were addicted to?
- What was it about your experience that made you think you were addicted?

[OR: explore how they would prefer to describe their AOD use]

When you're with this service, how do the workers talk about alcohol and drug use? Can you tell me about that? (what do they say to you)

- Do they use the word 'addiction' to describe problems with alcohol or drugs?
- Are there any differences between what services tell you about alcohol and drug use and your own experiences using drugs and drinking? Can you tell me a bit about that.
- Do you feel as though you are able to disagree with something a worker says to you about your own alcohol and drug use? Can you tell me about that?

What are your views on the best ways for services to help people with their alcohol and drug use?

Area 4. Participant's current circumstances

I'd like to turn now to asking you about other parts of your life, if that's okay. And I'll just remind you that you don't have to answer any questions if you're not comfortable.

Can you tell me a bit about your daily activities, how you spend your days?

- So you mentioned not having a place to stay at the moment. Can you tell me a bit more about that
- How long in this situation, how do you manage, are you getting help with this

OR

- Do you have a place to stay at the moment?
- How long have you been at this place?
- Do you live there with other people?
- What are your experiences living at this place. Good, bad, both? Can you give me some examples.
- Are there any changes that you would like to make to your housing?

- You mentioned you weren't working at the moment. Can you tell me how you get by for money?
- Is it hard getting enough money to cover your basic needs?
- Can you tell me about the people around you in your life at the moment?

Area 5. Personal goals

And so my last few questions are about what you might want from life now and in the future.

Can you tell me a bit about any goals or priorities you have for your life?

- Do you see taking alcohol and using drugs as being part of your life in the future? Can you tell me a bit more about that?
- Are there any challenges for you in having alcohol or drugs as part of your life?

Are there any challenges you find in your life at the moment? Can you tell me about these?

And the last questions are general background questions

- How old are you

- What's your gender
- What ethnic or cultural background do you identify with
- What suburb do you live in (or spend most time in [if not housed])
- What grade at school did you finish

So that's it for my questions. As I've said, this study is about learning about people's experiences and understandings of drug and alcohol use and their ideas about addiction. Is there anything else related to your experience of these issues that you'd like to talk about or anything else you think it's important that we should know?

Prompting questions:

- What do you mean by that?
- Can you say more about that?
- I think I know what you mean, but can you tell me a bit more about that?

Appendix F – Participant Demographics

Participant Demographics

Gender	Number
Female	8
Male	11
Other	0

Housing	Number
Supported accommodation	7
Private accommodation	10
Homeless	2

Age	Number
18 years	1
19 years	5
20 years	4
21 years	4
22 years	3
23 years	1
24 years	1

Cultural and ethic background	Number
Australian	11
Australian & European	5
Asian	1
Australian & American	1
Maori	1

Current source of income	Number
Centrelink	15
Parental assistance	1
Employment	3
Nil	2

* 2 participants noted more than one source of income.

Highest level of education	Number
Grade 6	1
Year 7	0
Year 8	4
Year 9	1
Year 10	7
Year 11	2
Year 12	4

Service attended	Number
Service A	6
Service B	13