

When addiction becomes visible.¹

Stephen J. Bamber, Liverpool Hope University

stephenbamber@gmail.com

05010715@hope.ac.uk

Recovery can only occur when addiction is made visible. Addiction is made visible when a certain set of material conditions is met, a set of conditions created by the interaction of complex ensemble of forces: laws, legislation, regulatory enactments (i.e. governance), social conventions, various scientific truths, ascribed levels of dysfunction and disorder and, as a corollary of this, the extent to which a particular drug-using behaviour incapacitates ones rationality, autonomy, and ability to function in consumer society.

For example, heroin addiction is highly visible as heroin has been a stringently controlled substance for roughly a hundred years. Those who choose to use it are subject to strict disciplinary regimes that have evolved over during time. Heroin/ opiate use has been exhaustively researched and studied, so there is a surfeit of scientific statements and truths about heroin and heroin addiction.

Significantly, heroin addiction is regarded as having a notably detrimental effect on ones rationality and autonomy. Liberal societies do not tolerate individuals who behave in a chaotic manner, who evidence a compromised ability to self-control, self-regulate, and who are unable to operate effectively within a matrix of production and consumption.

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Heroin addiction is highly visible because it penetrates innumerable areas on the surface of social and political concern. Thus, the most visible forms of addiction receive acute (and of course stigmatizing) attention. In the UK, individuals who fall into this deviant category are labeled Problem Drug Users (PDU's). Resources will always be privileged to measure, evaluate and ultimately normalize the most aberrant members of drug using populations.

Because heroin addiction is highly visible, recovery from heroin addiction is made possible. In fact, it is *demand*ed by the political economy. But what of less discernible addictions? We are living through a period of history that is bearing witness an accelerated increase in the visibility of highly differentiated forms of addiction. An important and instructive case that illustrates this process of rendering the invisible visible can be seen in the UK in addiction to over the counter (OTC) medicines, particularly those containing low levels of the opiates codeine and dihydrocodeine.

In 2007/08, the All-Party Parliamentary Drugs Misuse Group (APPDMG) heard evidence from a range of sources for the Inquiry into Physical Dependence and Addiction to Prescription and Over-the-Counter medication. This was a defining moment in the process of making OTC addiction visible, as it was at this inquiry that politics intersected with research (albeit scarce), anecdotal evidence, patient testimonials, public concern, popular reportage and commentary. This intersection of forces dramatically increased the visibility of this issue.

In response, in September 2009 the MHRA reinforced the governance of these products. Pharmacies were given new guidelines and exhorted to monitor sales of these drugs. New labelling and information on Patient Information Leaflets (PIL) explicitly indicated these drugs for moderate, chronic pain, to be used for a maximum of three days, with a clear warning that they have the potential cause addiction.² [1. Simply re-licensing such

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products Prescription Only Medicines (POM) is not an option, as it runs counter to the government's drive to diffuse the burden on GP's.] We can expect to see further studies to gather reliable evidence on the prevalence of OTC medication addiction, further guidelines, reports, committees, recommendations; all of which will contribute to an increase in visibility.

How does one recover from OTC medicine addiction? Generally - by yourself. There are a couple of well-established online support groups, Codeine Free Me,³ and Over-Count.⁴ Drug and Alcohol Action Teams (DAAT's) have no provision to offer support for this type of substance addiction. In fact, the APPDGM report recommended that people be treated in Primary Care rather than referred to DAAT funded projects.⁵

Unless OTC medication addiction develops into a disabling social problem that threatens the population's productivity, it is unlikely we will any specialist care in this area. It has not yet crossed, and perhaps never will cross, the threshold of visibility that triggers the type of provision given to Problem Drug Users.

To recover from addiction to over-the-counter medicines, peer-support is the only really viable option. One can access reduction protocols, obtain information and advice, and can plug-in to the power of shared experience. Unless we want to introduce people to the potentially suffocating, stigmatising environment of our drug treatment system, perhaps this isn't such a bad thing.

- Stephen Bamber, 3rd February, 2010

³ <http://www.codeinefree.me.uk/>

⁴ <http://www.over-count.org.uk/>

⁵ I have heard of two instances of people presenting with codeine addiction and being initiated on a methadone maintenance program. Clinicians' hands are tied when it comes to opiate substitution prescribing. There are only two universally licensed options - preparations containing methadone or buprenorphine - both heavy-duty opiates that are arguable inappropriate for treating codeine addiction. Although GP's can prescribe off-licence (e.g. prescribing codeine or dihydrocodeine for opiate addiction), in a litigious climate of restrictive clinical governance, most are reluctant to do so.