Article

Experimental Trajectories of Young Users of Psycho-active Prescription Drugs in Urban Indonesia

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Abstract

In Indonesia, a country with stringent drug laws, psycho-active prescription drugs (PPDs) have become popular among urban youth as they are seen to be safe – both medically and in terms of the risks of being arrested. During the ChemicalYouth project, which involved a multi-sited ethnography in urban centers in South Sulawesi (Makassar, Gowa, and Maros) and in Yogyakarta, we found that young people encourage each other to try out different kinds of PPDs to determine which (combinations) work best for them. Sharing their experiences, they jointly build up knowledge that guides their ‘experimental trajectories’ (Raikhel and Garriott 2013). The experimental trajectories of youths are enabled by pharmacies, where young people can buy PPDs, and private sector doctors who sell and prescribe PPD prescriptions. When certain PPDs become harder to get, young people will try out new substances in their search for happiness, highs, and the confidence and stamina needed to perform precarious informal sector jobs such as sex work, street singing, and helping people park their cars. Across the sites, the researchers encountered young people realizing that they had become addicted to PPDs. Simultaneously, health workers lack instruments to prevent harm related to PPD use as they work in public sector harm reduction programs designed narrowly to address illicit heroin addiction. We argue that educational interventions need to address the desires and aspirations for good enough lives that are reflected in young people’s creative poly-drug use practices, and the iatrogenic effects of unregulated pharmaceutical markets that enable medicalization of precarious lives.

Keywords

PPD, youth, Indonesia, harm reduction, addiction, experimental trajectories

Introduction

Like many other Southeast Asian countries, Indonesia is known for its draconian laws on drug use and trafficking. Upon his election in 2014, President Jokowi re-introduced the death penalty for drug traffickers. Shortly thereafter, the Dutch citizen Ang Kiem Soei and four others faced a firing squad for their alleged involvement in producing ecstasy; other highly publicized executions of drug traffickers soon followed. Indonesia has a long history of drug use and trafficking, with opium having roots in the precolonial and Dutch colonial era. In more recent decades, Indonesia has become a major producer of methamphetamines (locally known as *shabu*), the use of which is today more pervasive than the use of heroin. Media regularly report on raids on meth laboratories and seizures by the police (UNODC 2018). While the crackdown has made *shabu* more expensive and difficult to access, one unintended – but perhaps predictable – consequence is that young people, in large numbers, are turning to legal psychoactive prescription drugs to get high.

The non-medical use of psychoactive prescription drugs (PPDs) is a growing world-wide problem that affects individual well-being and creates costly problems for societies. According to the United Nation's 2018 *World Drug Report*, the non-medical use of prescription drugs has become a major threat to global health, with prescription opioids causing the most harm and accounting for 76% of drug-related deaths. A 2018 global health survey among 130,000 young people (aged between 18 and 35) found that 2.3% had used the prescription painkiller Tramadol for non-medical reasons over the past year (Winstock et al. 2018). In Indonesia, the national child protection agency recently reported that 5.9 million children (below the age of 18) out of a total of 87 million (a staggering 6.7%) are using drugs, prominent among them the psychoactive painkiller Tramadol and cough syrups that if ingested in large enough quantities can induce highs (Rakhmat and Tarahita 2018).

Under Indonesian Law No. 35/2009, the list of the country's controlled substances is divided into three groups based on the substances' risk for addiction and potential therapeutic value. Group 1 drugs include heroin, cocaine, marijuana, MDMA (ecstasy), and methamphetamine, which are viewed by the Indonesian government as therapeutically useless and with a high potential for addiction. Possession of group 1 drugs can lead to life imprisonment and the death penalty for convicted drug traffickers. Group 2 drugs include morphine, methadone and oxycodone. They are seen to have some therapeutic value but are perceived as dangerous because of their potential for addiction; their trafficking and possession can result in imprisonment. Group 3 drugs include PPDs with therapeutic value (codeine and buprenorphine), and penalties are not very clear. In the local language, drugs in group 1 and 2 tend to be referred to as *narkoba* (narcotics), while PPDs are referred to as *obat resep* (prescription drugs).

The prevention strategy of Badan Narkotika Nasional's (BNN, *Indonesian National Narcotics Agency*) mobilizes fear to emphasize the addiction risks of illicit (group 1) drugs. It runs rehabilitation programs for their users, who are committed to rehab centers and forced to go cold turkey for several months while receiving counselling. A different approach is followed by the National Commission on AIDS. As injecting drugs remains a key transmission route for HIV, it runs harm reduction programs that offer heroin users the injecting of methadone as a substitution. Although BNN has recently begun to acknowledge the widespread use of PPDs, including those in group 3, its educational efforts clearly lie elsewhere. In the absence of effective regulation, young people access PPDs through pharmacies that sell the drugs over the counter without prescription, and through street dealers.

The off-label use of PPDs by young people is part of a worldwide trend (Coveney, Gabe and Williams 2011; Dumit 2012; Jenkins 2010; Rose 2007; Quintero and Nichter 2011). Lin and Zhang (2014) for example describe how the young users of PPDs whom they interviewed in a Shanghai detention center emphasized the emotional, social and psychological benefits of 'skating ice' (sniffing methamphetamine) and taking ecstasy, ketamine and other synthetic drugs. Drug taking for them had been a means to achieve socially acceptable goals; businessmen, for example, used synthetic drugs to cultivate connections. Green and Moore (2009) likewise describe how middle-class youth in Western Australia use 'dexies' (prescription drugs containing dexamphetamine) to 'drink like a trooper while maintaining bodily control' and to 'enjoy socializing for longer periods without getting too messy' (Green and Moore 2009: 408). Compared to getting drunk, female informants also reported feeling safer and more in control when using dexies.

The ChemicalYouth project was designed to elicit interpretative understandings of why young people turn to 'chemicals' – illicit drugs, off-label prescription pharmaceuticals, enhancement products of various kinds – to achieve their everyday goals. Working with a team of youth ethnographers, we conducted multi-sited ethnography (Hannerz 2003) in Indonesia, the Philippines, France and the Netherlands, examining patterns of drug use in different settings. Across the sites, we inquired about *what* youth want to achieve by using drugs; *how* they use drugs to achieve their desired mental and bodily states; and how local policymakers, harm reduction initiatives, and health workers view and respond to these emerging trends. This article presents an analysis of the use of PPDs to enhance mental well-being in four ChemicalYouth sites in Indonesia.

Instead of focusing on a handful of 'problem drugs', the focused ethnographies examine what Indonesian youth want to achieve by using PPDs. Our premise is that if we want to minimize the harms of PPD use, we need to first understand both how and why young people turn to these drugs – their concrete practices of drug use and the aims they wish to attain. We also present the views and experiences of policymakers and health workers, who seek to reduce drug-related harm in the field sites.

Methods

Settings

The study was carried out in urban centers in South Sulawesi (Makassar, Gowa, and Maros) and in Yogyakarta. Makassar is the metropolitan capital city of South Sulawesi; Gowa and Maros are smaller towns near Makassar. Yogyakarta on the island of Java is a renowned center of education; it hosts a large student population and numerous schools and universities. Both Makassar and Yogyakarta have methadone replacement programs, while persons addicted to illicit heroin from Gowa and Maros are referred to Makassar. Makassar has one public hospital and five public health centers (*Puskesmas*) offering methadone replacement treatment; Yogyakarta has two hospitals and three *Puskesmas* offering this service. Policies differ slightly between the sites. For example, those who want to enter the methadone program in Makassar must have been using heroin for at least one year, as shown in laboratory blood tests. In Yogyakarta, the period is six months.

Informants and Recruitment

We conducted ethnographic interviews with regular users of PPDs and other illicit drugs. In Makassar, we interviewed 20 young people (11 students, 6 unemployed youths living with their families, 2 working for their families, and 1 working in a car repair shop). In Gowa, our 20 informants included 10 high school students, recruited through an acquaintance of one of our junior researchers. In Maros, our 17 informants, all male youth, included the owner of a printing business, 2 workshop employees, a mechanic, 2 unemployed persons, 1 school dropout, and 7 students. In South Sulawesi, we encountered difficulties obtaining consent for interviews from women using drugs as their drug use is more covert than that of their male peers. All of our informants in South Sulawesi were therefore men. In Yogyakarta, we were able to interview 4 female and 7 male users of PPDs.¹ In addition, we interviewed police officers, (assistant) pharmacists, outreach workers, and staff at community health centers and at the BNN both in Makassar and Yogyakarta.

For recruitment, we worked with harm reduction NGOs: the *Makassar Harm Reduction Community* and our colleagues from the University of Gadjah Mada in Yogyakarta who introduced us to *Persaudaraan Korban Napza di Yogyakarta* (Narcotics and Addictive Substance Victim Brotherhood of Yogyakarta). In Gowa and Maros, there are no harm reduction NGOs, so we recruited informants were through snowball sampling.

Data Collection

To gather data on the young people's experiences with PPDs, we asked the informants to fill in a self-administered four-day chemical recall, which included items on the kinds of drugs used, the dosages involved, and for what purposes. After the recall, usually in the same session, we held an in-depth individual interview on the

¹ A 2010 survey conducted by BNN and the Center for Health Research, University of Indonesia, found male drug users outnumbering their female counterparts five to one (BNN and Puslitkes-UI 2011).

positive and negative effects of each drug reported in the recall, on what factors influenced informants' use of specific drugs, and how they learnt about and acquired them.

The results of the recalls and interviews were discussed in three focus groups in Makassar, involving nine, six and eight participants respectively, and a focus group in Yogyakarta with nine participants. In the focus groups, we placed samples of products mentioned in the individual interviews on the table to elicit group discussion. We asked participants to rank the drugs on the basis of which most individually suited them or had the best effects. We also delved further into themes and issues that emerged in the interviews and four-day recalls. The focus groups allowed us to validate our observations and probe more in-depth into specific themes.

Interviews and focus groups were conducted and recorded only after we received consent. They took place in venues where our informants felt secure discussing drug use. Most interviews across the three sites took place in NGO offices, as did the focus groups in Makassar. In Gowa and Maros, the focus groups were held in a house where our informants frequently gathered. In Yogyakarta, the focus group took place in our fieldwork homestay. Throughout the research, we emphasized that we were interested in our informants' perceptions and experiences. We strove to listen carefully to their stories and not to be judgmental. We found our informants to be eager to share their experiences with us; many appreciated the reflexive space that emerged in the individual and group interviews.

Analysis

We recorded and transcribed all individual interviews and group discussions and entered them in a digital database, using NVivo 10. We began by identifying themes that emerged from the transcripts, such as *coba-coba* (trying out), *cocok* (compatibility), *campur* (mixing), *enak* or *bagus* (feeling good), *heppi/senang* (happy), *mabuk* (high), *pede* (confident) and *sakaw* (withdrawal) – the usual first step in ethnographic analysis (Fetterman 2010). These terms were then included in a coding scheme used by our assistants to analyze the data. Subsequent queries identified further themes, advancing the focused and iterative analysis of data. Youth ethnographers participated in the analysis of data and used their subsets of data to write chapters for the Indonesian-language edited volume *Bukan Narkoba, Bisa Berbahaya* (*Not Narcotics, Can Be Dangerous*) (Idrus and Kutanegara 2018).

Ethical approval was obtained from the University of Amsterdam, which stipulated that interview transcripts be anonymized, and verbal consent procedures be followed. We further obtained official research permits from the provincial as well as city/regency authorities to conduct research in their respective areas. We scraped interview transcripts of all information that could disclose our informants' identities. All names in this article are pseudonyms.

Experimental Trajectories

In a setting where the war on drugs criminalizes illicit drug use, we found a limited list of fairly cheap and easily accessible PPDs used in all of our field sites, with only minimal variation. An important segment of the PPDs we encountered were heroin-replacement drugs such as methadone and Subutex (buprenorphine), which are appreciated for the quality of the highs they induce. Our informants told us that PPDs are cheaper and easier to obtain than *putaw* and *shabu* (heroin and methamphetamine). They also considered using PPDs – which are not considered *narkoba* (narcotics) – to be safer as they are legal and sold in pharmacies. Many emphasized that with the ratcheting up of the war on drugs, it had become dangerous to possess *narkoba*; they feared being arrested. Some had experience with injecting drugs; others did not. Some told us that their drug use trajectories had begun with *shabu*; others, with *putaw* or prescription drugs. Some were already involved in methadone substitution programs, although most were now using methadone as another way to get high for free.

Fajar from Makassar, who had just graduated from high school, told us:

I already smoked in my teens. I learnt about *putaw* from observing my uncle injecting every day, so I asked him if I could try it out. I had no idea about the effect, until I experienced withdrawal when the high effect went away. I am HIV-positive due to my needle sharing habit, am co-infected with TB, and have been hospitalized a number of times.... I also use various prescription drugs like Somadril, Tramadol, Calmlet. I also got involved in the methadone program.

Upik from Yogyakarta, a *shabu* user, observed her husband taking *putaw* every day, tried it, and became addicted. Kamil from Makassar, a university student, substituted *putaw* with Subutex but when it was not available, tried Suboxone. Now, Calmlet, Subutex and Suboxone (whichever are available) have become his daily drugs of choice to feel better and to ‘unblock’ his brain. He also takes *Inex* (ecstasy) once in a while, usually when he goes clubbing. ‘*Inex* is good for tripping, it feels like flying’, he told us.

Most of our informants used PPDs on a daily basis. Our four-day recalls and probing of chemical products in the focus groups revealed the popularity of a limited number of narcotic substances and PPDs, along with shared insights on their pros and cons. Table 1 shows the most popular illicit and prescription drugs and their beneficial as well as adverse effects as experienced by our informants.

Table 1. Commonly used illicit drugs and PPDs and their experienced effects

	Content	Desired effects	Adverse effects
Group 1 Drugs			
<i>Putaw</i>	Heroin	Getting high; working and thinking well; feeling creative, calm, good	Short lasting (commonly 3 hours), feel lazy, isolated, easily get sick, weight loss
<i>Shabu</i>	Methamphetamine	Getting high, calm, agile, creative, feeling good, talkative, confident	Difficult to sleep, not feeling hungry, paranoid, becoming thin, hallucinations, easily get sick, lazy
Inex / Ecstasy / Triple-X	MDMA	Flying	Dry throat
Ganja / marijuana	Cannabis	Happy, good appetite	Starving, sleepy, limp, looking stupid
PPDs			
Methadone	Methadone	Strong high, long lasting	Strong withdrawal, lazy, un-communicative
Subutex	Buprenorphine	Flying	Vomiting
Suboxone	Buprenorphine with naloxone	Flying	Vomiting
Alprazolam	Alprazolam	Confident, brave	Sleepy
Calmlet	Alprazolam	Confident, creative, talkative, sleeping well, thinking well, brave, calm, feeling good	Convulsion, forgetful, easily get sick, unconscious, sleepy, black eyes, shaky
Dextromethorphan (Dextro)	Dextromethorphan	Confident, stamina, euphoria, cheap, feeling high, happy, not tired	Itchy, dry throat, blurry eyes, dizzy, oblivious, nausea, confused, vomiting, hallucination, indifferent, looking crazy
Kode-15	Dextromethorphan	Fast effect, long lasting, not tired	Itchy, cough, flu

Trihexyphenidyl (Trihex / Tehad / THD)	Trihexyphenidyl	Confident, flying, calm, happy, long lasting	Dry throat, itchy, headache, forgetting, blurred vision, sweating, stomach ache, nausea, paranoid, talking alone, dry throat, red eyes, feeling hot, vomiting, limp
Tramadol	Tramadol	Long lasting, calm, happy, flying	Itchy, sleepy, stomachache, nausea, vomiting, losing weight, blurred vision
Somadril (Somad)	Carisoprodol	Flying, confident, less shy, immediate effect, enhanced libido, stamina	Headache, itchy, looking stupid, no appetite, limp, emotional, sleepy, nausea
LL	Unknown	Flying	Dizzy
Riklona	Clonazepam	Flying	Insomnia
Esepuluh	paracetamol, caffeine, ephedrine	Flying	Insomnia
Codeine	codeine	Sleep well	Itchy throat, not feeling well

Most of the drugs listed in the above table were used in both Yogyakarta and in our urban field sites in South Sulawesi. Somadril, the PPD which the Indonesian Food and Drug Authority has taken off the market, remained popular among our informants in South Sulawesi. The PPDs Riklona, Codeine and Kode-15, popular among our informants in Yogyakarta, were not used by our informants in Makassar.

Balancing Acts

Much of the discussion in the individual interviews and focus groups revolved around enhancing the beneficial effects and avoiding the adverse effects of PPDs. These balancing acts differed depending on what was at stake in their everyday lives. For example, young women engaging in sex work sought to avoid ‘flying’ as this could make them more vulnerable to sexual violence (Hardon and Ihsan 2016). Students adjusted dosages in order to be alert enough to go to school and do their homework.

Our informants further observed that effects differ from one person to the other and emphasized the need to find out whether specific drugs are *cocok* (compatible)

with their bodies. The concept of *cocok* is not simply about suitability of a single substance, but about mixing the drug with drinks and food, and about getting the dosage right. One of our informants in Gowa, Broken (17), described how he initially took the painkiller Tramadol to get high and feel more confident. But after trying Somadril, it became his drug of choice; he consumed this psychoactive painkiller on weekdays and Saturday nights as it made him feel high, confident and courageous, while it also increased his appetite. He observed that Somadril's effects appear sooner when he eats spicy food, especially handy when jamming on Saturday nights. But when combined with alcohol, Somadril's effects are less pronounced and short-lived. He thus drinks alcohol when the effects of Somadril have subsided after two to three hours.

Finding one's *cocok* involves trying out and combining drugs for different purposes. Dirham (23), a parking attendant in Yogyakarta, began experimenting with ecstasy to feel *kuat kerja* (strong for work). But he gave it up because of its dry throat effect; he now takes Riklona and/or Calmlet for work and combines marijuana with beer to make him feel happy after work. Yayan (18) a Yogyakarta street singer who previously favored marijuana and heroin, subsequently tried out two different brands of cough tablets, taking up to 50 tablets of Dextromethorphan and 40 tablets of Kode-15 at a time to speed up and prolong their effects. Once he combined 20 tablets of Kode-15 and 10 tablets of Trihexyphenidyl, which made him sleepy. On other occasions, he mixed Tramadol, Calmlet and a local traditional drink (*ciu*), which caused him to vomit and cough up blood.

PPDs have different, sometimes contradictory, effects on individuals. Tramadol makes Zaky sleepy, causes Amir to stay up longer, and Mamat to experience itchiness, swelling, and ulcers. Drugs are considered *cocok* when the high is strong and they have no significant adverse effects, or when these adverse effects (e.g. nausea, vomiting) can be tolerated or managed. In Maros, Romo (14) reported his favorite PPDs to be Somad and Tramadol. The former on its own can produce a strong effect, so Romo does not combine Somadril with other drugs. But as Tramadol has a more pleasant toning effect, Romo combines two tablets of Tramadol with three tablets of a drug called LL (which on its own, makes his throat feel dry and his head dizzy). The choice to combine Tramadol and LL not only has to do with the sensation, but to neutralize LL's side effects.

Adjusting Dosages

Fine-tuning PPD use also involves finding the right dosage, which varies from one person to the next. Yani from Yogyakarta, a junior high school graduate, began with 15 tablets of Dextromethorphan twice a day before doubling the dosage to get high faster. With Kode-15, Yani takes between 20 and 30 tablets twice a day. These drugs make her fly, happy, indifferent to risks, and keep her from feeling tired. She finds these PPDs not only *cocok* for her individual body, but for her work as a street singer. Amir (24) commonly takes a strip (ten pills) of Tramadol or So-

madril each day. Yayan (18) takes 50 tablets of Dextromethorphan or 40 tablets of Kode-15, often falling unconscious as a result. Others complained that the dosages of Dextromethorphan required to get high (15-50 tablets) was too much and ‘not tasty’ (*enak*).

Table 2. Dosage ranges reported for selected PPDs

Drug	Dosage (tablets)
Suboxone	1/4-2
Subutex	1-2
Calmlet	2-5
Riklona	2-5
Tramadol	2-40
Somadril	2-30
Codeine	10-15
Trihexipenidyl	2-20
Kode-15	2-40
Dextro-Plus	30-40
Dextrometorphan	15-50

Somadril was the PPD of choice in our sites in South Sulawesi. In our focused ethnography on the use of Somadril by sex workers in Makassar (Hardon and Ih-san 2014), we observed them taking larger and larger doses over time. While the prescription painkiller bolsters sex workers’ confidence to approach prospective clients, it became increasingly unclear to us whether they were taking Somadril to work or working to take Somadril. The lion’s share of their income went to feeding their habit. The three male and three female sex workers who filled out 4-day recalls reported using between 6 and 24 pills a day, far above the recommended daily maximum. They craved Somadril, suffering all kinds of aches and pains, anxiety, and insomnia when they could not get it.

Informant	Pills per day	Reported beneficial effects	Reported adverse effects	Reported withdrawal effects
Mira female, 24	3–10, average 7	Confidence, increased sexual desire	Dizziness, falls asleep with too many pills, headache	Neck and shoulder pain
Naimah female, 22	3–10, average 5	Feels comforted, less shy, more happy, less resistance to sex with clients	None reported	Throbbing eyes, crying, bad mood, insomnia
Rina female, 20	8–16, average 10	Confident, less shy, happy, stays awake and flies high	Dizziness	None reported
Hasan male, 22	7–23, average 16	Confident, more talkative, can stay up late; fly high; feels less stress, enjoys himself more and has more sex; weight loss	Nausea, makes you stupid, thinking too much, hard to move; insomnia or sleepy (depending on dose)	Headache and bad mood
Udin male, 24	5–10, average 8	Confident, less shy, happy, stronger	Feels sick and hungry, vomiting. If too much: angry, delirious, cannot walk, stomach problems	Sleepy, anxious, sad, crying
Rudi male, 23	21–31, average 24	Confident, calm, sleepy	Diarrhea, trembling	Headache, thinks a lot

Table 3. Somadril daily dosages and reported effects among sex workers

In Gowa, we encountered intense PPD use by high school students on Saturday nights. They gathered on the ‘compulsory nights of drunkenness’ to drink and pop extreme dosages of PPDs to get high and feel courageous during motorbike races and to make mischief, disturbing other motorists, bumping into sidewalks or other vehicles. Zaky (17) told us that he usually takes up to ten Tramadol tablets per day but increases his dosage to 40 tablets on Saturday nights. Mamat (16) told us he usually takes 15 tablets each weekday. For him Tramadol is a ‘life encouragement’, without which he would feel sluggish. To prepare for Saturday night, he consumes 7 tablets of Tramadol in the morning, 15 tablets in the afternoon, and 7 tablets or more in the evening, dosing gradually until he reaches his desired high. Harianto (16) told us of the time he combined ten Tramadol tablets with five bottles of Topee Rioja beer. He raced around the city of Makassar with his friends until he hit a food vendor on the roadside.²

Dosages also depended on young people’s financial resources. Depending on whether one bought it in the pharmacy or from a street dealer, Tramadol, the cheapest of the PPDs, costs around Rp 2000-3000 per tablet; Xanax, Calmlet and Somadril cost much more. Swan, a student from Makassar, explained:

Sanax and Calmlet are a bit expensive. Sanax is Rp 6,000 per tablet, that’s 1 mg. ... Alprazolam is available in 0.5 and 1 mg doses, the 1 mg one is sold for Rp 5,000 per tablet, for Calmlet the price is Rp 8,000 for 2 mg ... but it is cheaper nowadays, because alprazolam is generic, yes, generic drugs are easier to get. If I take alprazolam, at most I take 6 mg a day, 6 mg is already a lot ... if I want it and have money, I can do it every day, but if I don’t have money, I don’t take the drug at all. Sometimes I was only able to get more after several weeks, after getting money, it depends on whether I have money or not.

² See also Fauzan (2018), a focused ethnography of these high school students in Gowa.

Figure 1. Youth enjoying time together, Yogyakarta. Picture taken by Sari Damar Ratri (November 2016).

Jono (13) told us he had been using PPDs since the first year of high school. A year later he became a dealer, using the profits to buy school supplies, snacks, clothes, and more drugs:

Sharing with friends, then my friend or I will go buy Tramadol (for Rp 1,500-2,000 per tablet). We then sell them for Rp 3,000 to 5,000 per tablet. So, the money earned is shared, and is used to buy drugs again.

Across the sites, we encountered young people realizing that they had become addicted to PPDs, in the sense that they need PPDs daily to stay well. Addiction was a common theme in our discussions with students in Maros and Makassar. Jack, a 21-year-old student in Makassar, told us that he had been taking Tramadol since high school:

Initially it was because of my friends... later on I got hooked and addicted... it's difficult to kick the habit, just like cigarettes.... It depends, usually I take one strip a day, but if I am really upset, I could take five strips...

In Maros, Aco told us he initially tried PPDs only to be accepted into his peer group, but over time it became as necessary as food. Similarly, Romo told us:

It's hard, it's very difficult to stop, even if I were paid any amount I would not stop, I just have a different feeling if I don't take the drugs. If the drug is no longer available, I would maybe make it myself.

Some of our informants did manage to kick their habits, especially when they were caught by their parents. Nur recalls how his parents grounded him and he lost contact with his friends. According to him, if he uses again, he will become addicted. Amin was caught using PPDs while in middle school. His parents went as far as sending him to Papua to keep him away from friends who were considered a bad influence.

The Response of Health Workers and Policy Makers

The health workers we interviewed in Makassar and Yogyakarta were concerned about youth experimentation with PPDs and the high dosages used but reported that they lacked instruments to confront the problem. One of our key informants, a BNN employee in Yogyakarta, pointed out that in addition to laws on illegal narcotics (UU No. 35/2009), there is an administrative order on psychotropic drugs (UU No. 25/2007). But the latter does not provide any instruments to discipline the 'naughty doctors' who prescribe and pharmacists who sell the PPDs. He also pointed out that young people can easily purchase the drugs online (e.g. www.jualrikona.blogspot.com).

The Indonesian Food and Drug Authority (Badan POM) is responsible for monitoring medicine provision and use,³ and is aware of the misuse of PPDs. One senior policy advisor told us that efforts have focused on stopping the production of commonly abused PPDs. This has happened for Carisoprodol (the active ingredient of the painkiller Somadril).

Badan POM adopted a regulation (HK.04.1.35.06.13.3534/2013) that allows cancelling licenses for medicines that contain Dextromethorphan single dosage. Based on this regulation, 130 kinds of drugs that contain Dextromethorphan were removed from the market, starting from 24 June 2013. But these actions do not appear to have had much impact. Single dosage dextromethorphan is still on the market as cough tablets, while Somadril (probably a counterfeit version) remains on the market in Makassar.

³ Presidential Decree Number 166/2000 (Article 73) states: 'BPOM has the task of carrying out government duties in the field of supervision of drugs and foods in accordance with the provisions of applicable laws and regulations.'

According to other key informants, Badan POM carries out inspections of pharmacies that sell large quantities of PPDs. But often, news of the inspection leaks out beforehand; officials therefore rarely unearth irregularities in the field. Moreover, if pharmacies are found to be selling drugs without prescriptions, Badan POM cannot take direct action against the pharmacy as its authority is limited to the supervision of products. If there is a violation, Badan POM can only send a warning letter to the Health Office.

In both Makassar and Yogyakarta, we were told that psychiatrists provide easy access to prescriptions for PPDs. In Yogyakarta, we encountered a Riklona and Calmlet boom as they were being prescribed by a psychiatrist, 90 tablets at a time. One Yogyakarta pharmacy was found to have sold 17,000 Riklona and Calmlet tablets per month; another pharmacy belonged to a psychiatrist who has ‘queuing patients’ each night. In Makassar, our informants told us that they could buy prescriptions at the clinics of psychiatrists without seeing a doctor. The cost for each prescription ranged between Rp 15,000 and Rp 30,000 (approximately US\$1.50 to \$3), depending on the requested quantity of pills.

In Yogyakarta, the growing abuse of PPDs has led the local government to sign a Memorandum of Understanding with the Badan POM, the municipal Health Department, pharmacies, and the police to restrict prescribing. Prescribing is now monitored. A prescription can be for no more than 30 tablets per week and is based on the philosophy of ‘one doctor, one pharmacy’, with only psychiatrists able to prescribe PPDs. This means that a patient can only get the drugs from the pharmacy referenced for the psychiatrist. One psychiatrist responded to the strict control of Riklona and Calmlet by announcing on the outer wall of his clinic: ‘no prescription for Riklona and Calmlet’.

In Makassar, we found that when certain drugs became difficult to obtain and/or were no longer available due to control by the authorities, other drugs emerged. Our informants repeatedly stated: ‘mati satu, tumbuh seribu’ (one disappears, thousands will emerge). The trends are fluid as new popular drugs appear and others disappear. Early on in our fieldwork in Makassar, Somadril was the most popular prescription drug; Tramadol was only used when Somadril was unavailable. A year later, Tramadol had become the new drug of choice. Somadril, although not completely absent from the market, had become difficult to obtain, although a new version of loosely packaged Somadril had emerged, most likely an imitation produced by the local cottage industry.

NGO outreach workers in Makassar have tried to confront private sector psychiatrists who overprescribe PPDs. They told us that the psychiatrists respond that they ‘know what they are doing’, claiming that their patients suffer from withdrawal symptoms and need treatment. While they were often genuinely trying to help young people with addiction problems, psychiatrists noted that they lacked time for individual screening and careful diagnosis. According to the workers, the psy-

chiatrists chose to just write prescriptions, sometimes even without seeing the patients. In addition, as Brown and colleagues (2012: 81) found, physician often prefer to prescribe what patients demand than risk arguments. Our informants told us about patients threatening psychiatrists with guns and swords, although no such cases had been reported to the police.

While control over prescription drugs was stricter in Yogyakarta (a number of pharmacies had been closed for selling PPDs without prescriptions), in Makassar, a well-known drug store selling PPDs without prescriptions to ‘regular customers’ was located close to the police office and had never been raided. A policeman in Makassar pointed out that youth who use PPDs are not engaging in illegal activity and thus cannot be charged; they are released after being ‘advised’ not to abuse PPDs in the future. Overall, the police are more interested in arresting dealers and users of group 1 – *narkoba*, as acting on illicit drug use is considered heroic in the currently intensified war on drugs, giving promotion points and offering opportunities to demand bribes from offenders, who fear that they will be imprisoned if they do not pay the bribe.

Discussion

We observed across our urban sites in Indonesia how young people experimentally combine PPDs with illicit substances and heroin substitution drugs. Our fieldwork further suggested that prescription drugs have become more popular than illicit drugs as they are seen to be safe ways of enhancing mental well-being, while at the same time avoiding being arrested for the possession of drugs. We observed youth encouraging each other to try out different, affordable psychoactive substances to find out which (combinations) work best for them. Sharing their experiences with each other, they jointly built up knowledge that guides their ‘experimental trajectories’ – a concept Raikhel and Garriott use to draw attention to the ways in which people who uses drugs ‘throw... [themselves] into a series of personal experiments’ (Raikhel and Garriott 2013: 27).

PPD use in Indonesia is facilitated by processes of ‘pharmaceutical leakage’, a term Lovell (2006: 146) uses to refer to the circulation of buprenorphine outside of therapeutic settings. Such leakage occurs in many settings in the Global South where drug regulations are weak and/or not fully implemented (Ecks and Basu 2009). The experimental trajectories of our informants suggest that over time, PPD use escalates along with the desire for stronger highs. To achieve these stronger highs, young people mix different PPDs, PPDs with alcohol, PPDs with hot food/drinks, and experiment with diverse ways of administering drugs (oral, injection, injection of crushed oral tablets). Along these experimental trajectories, they seek to avoid adverse effects such as being too high to work, feeling sleepy and vomiting. They consider a drug use regime to be *cocok* (compatible with their body) when there are no adverse effects or when the adverse effects are balanced by strong highs. They improvise when their drug of choice is unavailable or too ex-

pensive. The high-enhancing practices of mixing drugs with Sprite and hot food can be seen as a strategy to make the most out of the drugs given their scarce resources.

The drug use practices of our informants need to be situated in the precarious urban environments in which they seek to fulfill their aspirations fueled by a sea of media images that often sharpen the sense of exclusion and marginality for those who cannot afford the desired goods and lifestyles (Comaroff Comaroff 2000; Cole and Durham 2007). Many were struggling to make a living with limited educational achievements. Needing to work in the informal sector, they turn to drugs to induce confidence and stamina, selecting combinations that do not make them too disoriented. On other occasions, they seek to escape from the stresses of daily life by taking extreme dosages that make them ‘fly’.

Making sense of the experimental trajectories of our informants requires a bio-cultural understanding of how PPDs work. The escalating trends of drug use that we observed suggest that some of our informants are experiencing dependence and withdrawal symptoms, which they only seem to recognize as such for heroin and its substitutes. Many of the PPDs we encountered are known pharmacologically to lead to dependence when used regularly. This is the case for benzodiazepines as well as for potent painkillers such as Tramadol and Somadril. We suggest that the sex workers we studied in Makassar have become addicted to Somadril, craving the painkiller when they do not use it. Some students in our field sites use PPDs intermittently at parties and during periods of academic stress, as their peers do in urban areas in the USA and Australia (e. g. DeSantis and Hane 2010; Green and Moore 2009). However, other informants in our field sites used PPDs on a daily basis to enhance their mental well-being. Ready access to PPDs, unawareness of their full risks, and the belief that pharmaceuticals bought over the counter in pharmacies must be relatively safe have facilitated dependence and addiction.

Poly-drug use furthermore is common in our field sites. Most of our informants use several different kinds of PPDs regularly, at times substituting preferred drugs with other PPDs which are more accessible at the time, or cheaper. They also often mix PPDs with food and alcohol to enhance efficacies. They refer to the concept of *cocok* to indicate which substances and combinations make them feel good. *Cocok* is not simply about suitability of a single substance, but about mixing the drug with drinks and food, and about getting the dosage right.

The experimental trajectories of youths are enabled by private sector psychiatrists who easily prescribe and even sell prescriptions, while pharmacies often provide easy access to PPDs. Aware of the growing abuse of prescription drugs, Puskesmas staff are frustrated by these practices. Nevertheless, they lack the instruments to prevent harms related to poly-drug use as they work in public sector harm reduction programs. Emerging in the wake of the AIDS epidemic, these programs are

designed narrowly to address illicit heroin addiction and are ill-adapted to the experimental drug use cultures and the creative poly-drug practices that we observed, which now include the drugs meant to substitute heroin.

Harm-reduction programs in Indonesia, thus fail to acknowledge that young people also are at risk of becoming addicted to PPDs, including pain killers such as tramadol and carisoprodol and a range of benzodiazepines. They also fail to inform young people of the adverse effects of PPDs, when taken in large quantities for recreational purposes, when mixed with food and drinks to enhance effects, or when used to self-medicate withdrawal effects. Local level health and drug policy makers respond to the emerging PPD problems by limiting access to PPDs, but our ethnography suggests that young people can always find pharmacies or street dealers who are willing to sell them the drugs, or psychiatrists who are willing to prescribe them.

Experimenting with New kinds of Harm Reduction

Aware of the seriousness of the PPD epidemic and the risks that young people run without anticipating that prescription drugs can be as harmful as illicit drugs, we experimented with several novel harm reduction strategies. The first was to conduct feedback sessions with our informants, where we gathered the most commonly used PPDs and invited a pharmacologist to explain their pharmacological effects (through diverse administration routes). The pharmacologist's approach was dialogical, asking users about their preferred drugs and appealing to their experiential knowledge, followed by an explanation of the various ways in which the drugs enter and are metabolized in the body. His questions included whether participants had friends who had died recently. When the response was positive, he conducted a verbal autopsy, for instance, explaining that the victim's yellow skin pointed to liver failure. The young participants were keen to learn, revealing the latent need for education on the pharmacological effects of PPDs.

To generate greater awareness of the PPD problem, the first author – who is also a columnist for a local Makassar newspaper – reported on our findings in the local newspaper. She also gave talks at high schools on the use of PPDs to inform parents. We further co-created a three-minute YouTube video with the Jakarta-based youth communications collective Pamphlet, in which the core message was that prescription drugs are not necessarily safe, see Figure 2 for stills from this video.⁴ The first author also published the Indonesian-language volume *Bukan Narkoba, Bisa Berbahaya* (*Not Narcotics, Can Be Dangerous*) which included chapters on a variety of chemicals including PPDs used by young people in their everyday lives (Idrus and Kutaneegara 2018).

⁴ See <https://www.youtube.com/watch?v=TsLpt1bWzs8&t=124s>

When we were pursuing these outreach activities at the end of our project, a new presidential initiative (No. 3 of 2017) was announced: The National Action on the Eradication of Drug Abuse, with the slogan ‘Reject the Misuse of Drugs’. The joint commitment of the National Action on the Eradication of Drug Abuse was signed by 11 parties representing the government and all elements of society, including the Minister of Health, the Head of Badan POM, the Chief of Police Crime Section, the Indonesian Doctors Association, the Chair of the Indonesian Pharmacists Association, the Chair of the Young Generation Pharmacy students, and members of a popular band. Through this program, the BNN now commands more resources for education, an opportunity to scale up efforts for youth-friendly drug education. However, implementing youth-friendly harm reduction programs is easier said than done given the history of criminalizing users or approaching them as addicts in need of rehab. To be effective, the National Action Plan needs to address the lack of regulatory control that enables easy access to PPDs through pharmacies, the malpractices of psychiatrists who over-prescribe psychoactive drugs, and the economic interests that fuel these practices.

Figure 2. Three images from the Kok Bisa/Pamflet YouTube video *Apakah Minum Obat Bisa Membahayakan Kesehatan Kita?* (Can taking medicines cause harm?). The middle image refers to cough (batuk) medicine and pain (nyeri) medicine, and the right image calls on users to read the product information, including that on side-effects (efek samping).

Educational strategies need to speak to the dynamic experimental drug use trajectories of young people in Indonesia. When certain PPDs become harder to get, in

a situation fueled by the prevailing war on drugs, young people will try out new substances in their search for happiness, highs, and the confidence and stamina needed to perform precarious informal sector jobs such as sex work, street singing, and helping people park their cars. To address the experimental drug use trajectories of youth, harm reduction efforts need to go beyond addiction paradigms that see persons who use drugs as victims of potent substances. Instead, they need to address the desires and aspirations for good enough lives that are reflected in their drug use practices, and the iatrogenic effects of unregulated pharmaceutical markets that facilitate a medicalization of precarious lives.

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