



<https://theses.gla.ac.uk/>

Theses Digitisation:

<https://www.gla.ac.uk/myglasgow/research/enlighten/theses/digitisation/>

This is a digitised version of the original print thesis.

Copyright and moral rights for this work are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This work cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Enlighten: Theses

<https://theses.gla.ac.uk/>  
[research-enlighten@glasgow.ac.uk](mailto:research-enlighten@glasgow.ac.uk)

**Women Drug Users in North Cumbria:  
What are the influences upon  
their problem drug use?**

**Doctoral Thesis submitted August 2006**

**Jennifer A. M. Payne**

***Croeso*, 83a Main Street, St Bees  
Cumbria CA27 0AD**

**© Jennifer A. M. Payne, 2006**

ProQuest Number: 10390639

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 10390639

Published by ProQuest LLC (2017). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code  
Microform Edition © ProQuest LLC.

ProQuest LLC.  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106 – 1346

GLASGOW  
UNIVERSITY  
LIBRARY

## **Declaration**

I declare that this thesis, and the research on which it is based, to be my own work and testify that it has not been accepted in any previous applications for a degree, that all verbatim extracts have been distinguished by quotation marks, and that all sources of information have been specifically acknowledged.

Signed.....

Date.....12 June 2007.....

## **Abstract**

The predominant impression of women's problem drug use has been that they are encouraged or oppressed into addiction by male counterparts, and a stereotype has emerged of passive companions. More recently this has been challenged by research which has proposed that women may be active players in the decision to try illegal drugs, and that they may even use substances as an articulation of their emancipation. Most sociological research has tended to focus on male drug users who remain the majority population, but there is increasing evidence that gendered patterns of drug use are converging.

The overarching aim of this study was to provide a descriptive account of influences on women's problem drug use in North Cumbria, and to contribute to knowledge about their initiation into heroin use, as well as the pattern and progression of developing drug dependence. North Cumbria is a relatively isolated area and encompasses more than two thirds of the second most sparsely populated county in England. Cumbria contains some of the most spectacular countryside, juxtaposed with areas of multiple disadvantage, particularly along the coastal fringe. Despite its relatively remote location, North Cumbria experiences the effects of problem drug use, with heroin often identified as the drug of choice: recent data confirm that this is particularly evident within its more disadvantaged communities.

Qualitative methods were selected for this study because of its exploratory nature and intention to account for the influences on local women's drug use, which comprised the research question. It has previously been found that women drug users tend to be '*hard to reach*', and there were significant difficulties experienced in contacting participants, apparently because many women fear identification as addicts, particularly if they are mothers. Interviewees were therefore mainly contacted through sponsors in health and social care agencies in both the statutory and voluntary sector.

Semi-structured interviews were carried out with thirty women drug users, over a period of two years, using a prepared topic guide. This guide facilitated the setting out of the women's experiences and therefore broad topics of interest, derived from a review of the literature, were selected to allow the inductive

process to develop. Women were encouraged to tell the story of their drug use, often describing specific instances of using heroin within social settings, and they put forward opinions about any influences on their behaviour. Interviewees were also willing to share ideas for improvements in services for women drug users, which were derived from their own lived experience.

In order to analyse the data generated by the interviews a '*grounded theory*' approach was used to allow the themes and conceptual framework to emerge, during and throughout the research process (Glaser & Strauss, 1967). A complementary technique of '*theoretical sampling*' selected the study population on a continuous, theoretical rather than statistical basis, to seek new insights for the developing theory (Glaser & Strauss, 1967). This was premised on a belief that interviewees with different social characteristics and living in different locations within North Cumbria might add new elements in additional data, thus deepening and consolidating understandings. Themes and concepts were accounted for by describing any variations between women's experiences, and sampling ceased when '*theoretical saturation*' was reached because nothing new continued to emerge (Glaser & Strauss, 1967). Interviewees' responses underlined the heterogeneity of women drug users and their experiences, but consistent themes were identified and analysed.

The key findings from this study have been identified as the need to acknowledge: interviewees' declared agency in the decision to use heroin; their intention to seek pleasure from the heroin-using experience; their claims that certain predisposing factors might have made them susceptible to initiation; and their belief that the introduction of a peer-mentor intervention in North Cumbria could benefit other women drug users.

In conclusion, this study has expanded the argument which has queried previous castings of women addicts as merely compliant in their involvement in problem drug use. Indeed, it seems that it is erroneous to view women drug users as mere victims of the drug culture, since interviewees denied coercion and often said that they had chosen to use heroin from curiosity, or to seek new experiences. The women's assertion that certain predisposing factors might have made them susceptible to problem drug use, and that these issues had sometimes remained unresolved, implies that gender-sensitivity in assessments

is important, recognizing difference but avoiding stereotypical gender assumptions. Finally, many interviewees believed that a peer mentor support project could influence and promote recovery from addiction in North Cumbria, and it is both imperative and pragmatic that women drug users themselves are involved in the shaping of their local services.

## Contents

### Acknowledgements

	Page
Introduction	1
Research Methods and Methodological Issues	6
Chapter 1 North Cumbria: The setting and the study participants	23
Chapter 2 The Women's Initiation into Problem Drug Use	35
Chapter 3 Sharing and Risk: Lifestyle, drug-injecting and sexual behaviour	58
Chapter 4 Relationships: Influences and Risks Sexual Partners and Friends	91
Chapter 5 Relationships: Influences and Risks Families and Children	124
Chapter 6 Treatment for Addiction: Influences upon help-seeking	166
Chapter 7 Treatment for Addiction: Influences and interviewees' experiences	187
Chapter 8 Conclusions: Findings, implications and recommendations	217
Appendix 1 Interview topic guide	234
References	235

## List of Tables

	Page
Table 1 Interviewees' age in years	27
Table 2 Interviewees' drug-using status	29
Table 3 Interviewees' marital status	30
Table 4 Interviewees' civil status	30
Table 5 Interviewees' parental status	31
Table 6 Interviewees' current living arrangements	32
Table 7 Interviewees' educational attainment	33
Table 8 Interviewees' employment status	34
Table 9 Percentage who claim to have taken an illegal drug, not cannabis, within the last month (Balding, 2004)	37
Table 10 Percentage who claim to have taken alcohol and a drug on the same occasion (Balding, 2004)	37
Table 11 Percentage responding that they could buy alcohol in a pub or bar (Balding, 2004)	38

## **Acknowledgements**

I would like to thank all the women who took part in this study by sharing their stories, as well as the many friends and colleagues who facilitated contact. You all know who you are. Women often spoke about sensitive personal influences and experiences, and I hope that this research will contribute to changes in both policy and practice.

I am deeply indebted to my supervisor Professor Neil McKeganey, Centre for Drug Misuse Research, University of Glasgow for his guidance, constant support and inspiration. I would also like to thank Professor Michael Bloor, Dr. Marina Barnard and Dr. Sarah Cunningham-Burley who assisted me at different stages of this research. Grateful thanks are due to Cumbria Drug Action Team for financial support for this study, and to Sean McCollum, former DAT Coordinator, for his encouragement to undertake this project.

Finally, but not least, I am grateful to colleagues, family and friends for their interest in this work and to my husband, Anthony Payne, for his invaluable help with proof-reading.

## Introduction

Problem drug use can affect people from a wide range of backgrounds, but it has been proposed that women have been consistently under-represented in treatment services (Becker & Duffy, 2002; DH, 1997, 2000; NTA, 2002). This may still mask the true numbers of women drug users since concerns about stigma, confidentiality and child protection policies are believed to discourage presentation (Bate, 2005; Ettorre, 1992; Gurdin & Patterson, 1987; Lex, 1991; NTA, 2002; Powis *et al*, 1997; Underhill, 1986). Furthermore, women drug users have been highlighted as a group which has been under-served by mainstream service provision (Copeland & Hall, 1992; Ettorre, 1994; Hartnoll, 1992; NTA, 2002), and also seem to have different needs, as well as greater vulnerability to the physical, mental, social and medical consequences of drug dependence (Becker & Duffy, 2002; Ettorre, 1992, 1994; Hartnoll, 1992).

Drug use has been recognized as a socially-situated phenomenon (Bloor *et al*, 1992; Bloor, 1995; Bourgois *et al*, 1997; McKeganey & Barnard, 1992; Rhodes, 1997), and in women's pattern of consumption, which frequently involves relationships with male injecting drug users (IDU), they can be placed at increased risk of serious infection and illness by sharing potentially contaminated equipment, or through sexual contact (Davies *et al*, 1996; Gossop *et al*, 1994; McKeganey & Barnard, 1992). In this study in North Cumbria, it often seemed and remains a concern, that many of these risks were underestimated or not acknowledged. An omnipresent risk for drug-using mothers has been said to be the loss of custody of any children, and that in this addict role women are harshly judged as irresponsible and neglectful (Ettorre, 1992; Klee & Jackson, 1998; Kline, 1996; Marsh *et al*, 2000; Oppenheimer, 1994; Powis *et al*, 2000; Taylor, 1993, Vitellone, 2003). It has also been said that this public opprobrium can be extended to their transgression of socially prescribed gender-appropriate behaviour as daughters, sisters, wives and partners (Barnard, 1993; Ettorre, 1992; Lex, 1991; Perry, 1979; Robbins, 1989; Rosenbaum, 1981a; Swift & Copeland, 1996; Taylor, 1993; Underhill, 1986).

The prevailing assumption has been that male addict partners coerce or oppress women into using substances, (Anglin *et al*, 1987; Cuskey, 1982; Eldred &

Washington, 1976; Nurco *et al*, 1982; Parker *et al*, 1988; Reed, 1985; Suffet & Brotman, 1976), and a stereotype has emerged of '*passive and immature*' companions in addiction (Bury, 1992; Perry, 1979). Furthermore, it has been alleged that drug-using women are regarded as '*mad, sad, and bad*', alluding to the concept of their being psychologically disordered, victims of men's power or exploitation, and deviants from traditional feminine behaviour (Ettorre, 1992; Measham, 2002). These attitudes have been assumed to derive from enduring medieval religious and philosophical beliefs, which view women's hedonistic pleasure and loss of self-control as morally reprehensible (Ettorre, 1992; Measham, 2002).

It has been demonstrated that problem drug use can be strongly influenced by socio-economic conditions (ACMD, 1998; Frischer, 1995; Giggs *et al*, 1989; Parker *et al*, 1988), and that women's structural position may increase this impact (Carlson, 1996). Some commentators have argued that inequalities are inherent in gendered power relations (Holland *et al*, 1990b, 1992c; Maher, 1997; Taylor, 1993), and that the non-urban setting can provide its own set of inequalities (DEFRA, 2004; Rural Regeneration Cumbria, 2002), which may compound the effects of social exclusion upon vulnerable women (YMCA, 2002).

It has been said that sociological research has tended to favour the majority population of male drug users (Ettorre, 1992; Pettitway, 1997; Taylor, 1993; Rosenbaum, 1981a), but recent studies of their female counterparts have provided compelling insight into the lives of women involved in problem drug use, and have challenged the fore-mentioned stereotypes (Ettorre, 1989, 1992, 1994; Henderson, 1993, 1997, 1999; Maher, 1995, 1997; Measham, 2002; Rosenbaum, 1981a; Taylor, 1993). These studies have mainly taken place in cities in both the UK and America, and there is little evidence of attention to drug-dependent women in non-urban communities. Although North Cumbria may be defined as non-urban, this descriptive and analytic study did not intend to make systematic comparisons with studies of women's drug use in urban areas, but has noted any environmental influences which interviewees raised as significant. Neither did the study intend to establish how the situation might differ for interviewees' male counterparts, but it has recorded the women's comments.

The influences upon women's drug dependence may be evident within the social context, and this can best be revealed using qualitative techniques (McKeganey, 1995). Small-scale qualitative studies have the ability to explore and explain why certain phenomena occur, and can elucidate the perspectives of those studied. This study comprised a series of semi-structured interviews and these were carried out with women drug users from throughout North Cumbria. Interviewees' narratives described their lived experience, as well as their attitudes and beliefs about the initiation and development of their drug dependence.

This study has analysed and interpreted data derived from these accounts of women's personal experiences, and their opinions about acquiring, maintaining and eventually trying to relinquish a heroin addiction. The overarching research question has focussed on the influences upon women's problem drug use in North Cumbria, and this data has provided a source of explanation. Although this was not a comparative study of urban and non-urban settings, when interviewees remarked on any environmental influences on their drug use these were noted, where no equivalent explanation was evident.

The text includes extracts from the narratives, with pseudonyms protecting the identities of those involved, as well as any people or locations mentioned. The data extracts have allowed the power of the women's own words to be articulated, revealing their opinions about initiation into problem drug use and the pattern of their addiction. Women often spoke with polite scorn of "*book-learners*" or professionals who advise them about addiction but who "*could never really understand*": it is hoped that interviewees' viewpoints have been faithfully interpreted and represented in this thesis.

The heterogeneity of interviewees' experiences soon became evident, but consistent and persistent issues emerged from the analysis and are presented methodically within each chapter. The chapters are organised around the main themes identified within the narratives, and correspond with the evident pattern of interviewees' drug dependence. A review of the literature pertaining to the particular theme selected is contained within the text, so that the data can be located in the context of previous and existing research.

The opening chapter will provide background information about the study participants, and this will include details of their marital, civil or parental status, their living arrangements, their current drug-using status and any relevant socio-economic factors. It will also provide a brief overview of the setting in North Cumbria, to describe the context in which the research was undertaken.

Chapter 2 will begin to account for the findings of the study with an investigation of interviewees' initiation into problem drug use; this will also consider what is known about early drug use in Cumbria and elsewhere. The thesis will then go on to discuss factors which the women presented as significant for their drug-taking, some of which had provided an important context for their initiation into problem drug use. These included: susceptibility; curiosity; trust; and a range of social circumstances or life events. A male sexual partner was often present when problem drug use began, and it was explained to the researcher by interviewees that this influence was pivotal but not directly instrumental, since all the women owned their decision to become involved in problem drug use.

The focus of Chapter 3 then moves on to consider the risks inherent in the shared drug-using lifestyle which interviewees said had rapidly developed after initiation. The women often described using heroin with a male partner, usually within a drug-using social milieu, and the reasons and implications of sharing problem drug use will be explored. Within the women's accounts there were examples of risk-taking in both injecting and sexual behaviour, which often seemed to be under-estimated, and to be underscored by the pervasive influence of custom and practice within the drug-using sub-culture.

Illicit drug use has been widely recognised as a social-situated phenomenon (Bloor *et al*, 1992; Bloor, 1995; Bourgois *et al*, 1997; McKeganey & Barnard, 1992; Rhodes, 1997), and Chapter 4 will consider the way in which heroin use affects, and is affected by personal relationships, such as with friends and sexual partners. It will illuminate what women recalled about the impact of these types of relationships in the development, maintenance and treatment of problem drug use, as well as their statements about the attitudes and values which apparently gave meaning to certain high-risk behaviours. Whilst accounting for these influences upon their problem drug use, women denied that the decision to become involved in heroin use was anything but their own.

Chapter 5 will then progress to consider what interviewees said about both the impact of family relationships on their drug use, and the impact of their own heroin addiction on their families of origin. Once again interviewees rejected any assumption that the blame for initiation rested with anyone but themselves, but suggested that certain factors might have predisposed initiation. This chapter will include the drug-using mothers' accounts of how their addiction affected their children, as well as interviewees' claims about the catalytic effect of concern about child welfare on their motivation to become drug-free.

This will lead on to Chapter 6 where attention turns to the tipping point of the women's decision to quit heroin use and to seek help from treatment agencies, and it will account for the diverse motives involved. Interviewees described their emotions at this time, often indicating some ambivalence, and they also portrayed the barriers which they perceived in coming forward for assistance with their addiction. This chapter will highlight some of the influences which interviewees identified, and any specific issues which they mentioned.

Chapter 7 will develop this theme and will account for the women's experiences of treatment services, as well as their interactions with therapeutic professionals. Interviewees highlighted issues around: access to treatment and the length of waiting lists; choice of treatment and difficulties around using prescribed heroin substitutes; as well as the need for support with a number of particular concerns. Relapse to heroin use was said to be a disappointingly common occurrence, but a few interviewees were willing to share insight into their beliefs about sustainable recovery from dependence. The women's views about the most effective interventions at this stage of their drug dependence will also be described, along with their recommendations for a specific service development.

In the final chapter, the complex and diverse influences on the problem drug use of this sample of women addicts will be drawn together in a summary of key findings and conclusions. The limitations and implications of the study will then be reviewed and complemented with selected recommendations for both policy and practice. Finally, indications for future research, which have been prompted by the findings of this study, will then be presented.

## **Research Methods and Methodological Issues**

### **Research design and methods**

Qualitative methods were selected for this study because of its exploratory nature and its intention to articulate the influences upon local women's drug use; this comprised the overarching research question. The purpose of the study was to provide a descriptive and analytic account of influences upon women's problem drug use in North Cumbria, and to provide an explanation for the initiation into heroin use, as well as the pattern and progression of developing drug dependence. The use of this type of research to examine the processes by which both social structures and psycho-social factors are mediated at the individual level has already been advocated (McKeganey, 1995). A small-scale study such as this can provide a perspective on why, for example, risks are taken by the sample population, as well as identifying their occurrence. In addition, it has been asserted that participants need to be willing to disclose personal information, or to allow insight into attitudes and values, and this data could not have been generated by quantitative methods such as surveys and questionnaires (Hollway, 1989).

Semi-structured interviews were carried out with thirty women drug users in North Cumbria, over a period of two years beginning in 2002, using a prepared topic guide (Appendix A). The purpose of this guide was to facilitate the setting out of the women's experiences and therefore broad topics of interest, derived from a review of the literature, were selected to allow the inductive process to develop. The predominant sources of knowledge about women's drug use have been derived from studies set in urban locations, and no equivalent explanations from non-urban settings were currently evident. Whilst aware of this deficit, there was no intention to produce a comparative study to establish any differences with either men's drug use or with urban locations, but rather to provide a descriptive and analytic account of the influences on this sample of women's drug users. However, it could not be assumed that the setting had no effect upon the women's drug-using behaviours, and the report of this study may prompt the question of whether interviewees' experiences might differ at all because of the non-urban setting.

Topic guide questions were therefore not specific to the setting but, as part of the descriptive account, any environmental influences remarked upon by interviewees were noted as appropriate. The topic guide aimed to construct a framework for discussion, allowing the women to expand on their responses and to reflect upon attitudes, emotions and experiences, as far as their comfort allowed. Women were encouraged to tell the story of their drug use, often describing specific instances of using substances within social settings, and they put forward opinions about any influences on their behaviour. These broad topics selected included: choice of drug; method, situation and practices of administration; views of any influences on initiation and continued use; awareness of harm-reduction and any risk behaviours; current circumstances; as well as the presence of support or family networks; and any future aspirations. This framework generated several themes of influences which, after coding and analysis of the women's responses, were grouped to comprise chapter headings for this thesis.

Interviews lasted from an hour to an hour-and-a-half, and were audio-taped with participants' written consent, and were transcribed *verbatim* by the researcher. Pseudonyms have been used throughout this thesis to protect the identities of participants, as well as the people and any locations they mentioned. Interviews took place in agency premises, a residential rehabilitation unit, General Practice (GP) surgeries or occasionally in the women's own homes. Women were encouraged to share ideas for improvements in services for women drug users, and often expressed satisfaction at "*having a voice*": a short interim report has now been presented to Cumbria Drug Action Team to inform local service development. After the interview, a debriefing session was offered and several women were surprised to have enjoyed the experience: one claimed it had made her feel "*ten feet tall*". This also gave a chance to clarify any misunderstandings revealed in the interview and to offer appropriate health, harm-reduction or help-line information.

In addition to this session, women were asked to invite their partners, to an individual or joint interview, to try to gain a male perspective. If the couple were interviewed together, it might have been possible to observe any verbal or non-verbal interaction. However, it emerged that many women had ended relationships in their efforts to become abstinent or because of domestic abuse,

and some partners were serving custodial sentences for drug-related offences. A joint interview was possible on only one occasion, and because of this single perspective and methodological limitation, it has not been included in this thesis.

### **Specific ethical considerations**

Consideration was given to the sensitive nature of the topic and Lee (1993: 97) has pointed out that *'Telling another about those aspects of one's self which are in some way intimate or personally discrediting – confessing – in other words, is a difficult business. It becomes less so where privacy and anonymity are guaranteed and when disclosure takes place in a non-censorious atmosphere'*. He has gone on to point out that *'Within this framework (of trust) researchers can lead those studied to confront, in a fundamental way, issues which are deep, personally threatening and potentially painful'*. This implication, and the need to protect interviewees from further distress, recommended open-ended questions and an assurance that no response was necessary if the topic was too intrusive. Women were also assured of anonymity, although limits to confidentiality regarding concerns about the safety of any children and vulnerable adults were also explained. In addition, women were not interviewed if they appeared intoxicated in any way, but this only occurred on one occasion and another meeting was arranged.

### **Criteria for selection**

The criteria for inclusion were that women, aged over sixteen, were resident in North Cumbria and were, or had recently been, problem drug users. In this study, the definition of problem drug use employed was: *'that which has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Such drug use is likely to be heavy and dependent: substances involved are typically heroin or other opiates, benzodiazepines, cocaine or amphetamines'* (ACMD, 2003: 21).

### **Sampling strategy**

It is known that women's drug use tends to be more covert, described by Rosenbaum (1981a) as *'relative secrecy'*, and that they are often difficult to access for interview or treatment. Gaining access to women who were willing to be identified as drug users presented significant difficulties and the sampling

strategy became a methodological issue, which will be discussed more fully in the second half of this section.

### **Characteristics of the sample**

Interviewees were recruited from throughout North Cumbria: aged between seventeen and forty-two; in a relationship or single; an addicted mother and daughter; women with differing domestic arrangements, living in small or large towns, small villages or on a farm; varying levels of education; some women were in employment; and one self-identified as lesbian. A few confided that they had experienced mental health problems of both distress and disorder, and some interviewees had come into contact with the criminal justice system. Only one woman was not White British, but this is characteristic of Cumbria where Non-White communities comprise only 0.7% of the local population (ONS, Census, 2001). Chapter 1 will provide more detailed description of the social characteristics of the study sample, as well as information about the study setting in North Cumbria.

### **Data analysis**

In order to analyse the data generated by the interviews a '*grounded theory*' approach was used to allow the themes and conceptual framework to emerge, during and throughout the research process (Glaser & Strauss, 1967). This inductive approach is based on authentic accounts and was supported by the researcher's own observations. Initially, all of the data were reviewed manually to identify themes, concepts and emergent patterns or relationships. This technique uses constant comparison, by monitoring interviews and comparing similarities and differences within the accounts. A complementary technique of '*theoretical sampling*' selected the study population on a continuous, theoretical rather than statistical basis, to seek new insights for the developing theory (Glaser & Strauss, 1967). This was premised on the belief that interviewees with different social characteristics and living in different locations in North Cumbria might add new elements in additional data, thus deepening and consolidating understandings. Themes and concepts were accounted for by describing any variations between women's experiences, and sampling ceased when '*theoretical saturation*' was reached because nothing new continued to emerge (Glaser & Strauss, 1967). Interviewees' responses underlined the heterogeneity of women

drug users and their experiences, but consistent themes were identified and analysed.

This section has described the research methods used. In their execution a number of methodological issues relating to the principles and philosophy of this kind of study emerged, and these will now be considered.

### **Methodological issues**

The implementation of the study generated some methodological issues which were consistently evident. Amongst these, the most salient were the research relationship and the efforts necessary to access this '*hard-to-reach*' population, and it seemed that a few environmental influences were relevant. Good practice requires that these be considered carefully, and that deliberations are now set out to inform subsequent research.

### **Research relationship**

It has been asserted that the development of a close and equal relationship between researcher and interviewee is vital in qualitative studies, and can lead to the acquisition of more significant and meaningful data (Finch, 1984; Oakley, 1981). Furthermore, Spradley (1979: 78) explains that it is this *rapport* or development of mutual trust '*that allows for the free flow of information*'.

Awareness of the guidance of these and other researchers meant that establishing a non-judgemental environment, where such trust might flourish, became a priority.

In their study of pregnant women drug users, Murphy and Rosenbaum (1999) argued that a key aspect of establishing rapport was the fact that they were female researchers. They deduced that this was derived from socialisation into traditional gender roles (Chodorow, 1978), where women's listening skills and mutual support are emphasised. Furthermore, some commentators have claimed that the male victimisation experienced by some female interviewees may present an additional reason for a gender preference (Broom, 1994).

Padfield and Procter (1996) interviewed young women about their future aspirations and demonstrated differences in the types of sensitive information revealed to each researcher, with a gender-based pattern of partiality emerging. Whilst supporting this premise of gender preference, feminist commentators have also written extensively about the issues of hierarchy which may be present

when interviewing women whose structural position, because of social class, education or age, differs from that of the researcher (Finch, 1984; Maynard & Purvis, 1994; Oakley, 1981; Reinhartz, 1992). Particular emphasis must be placed on minimising these power differentials (Wilkinson & Kitzinger, 1996) which can privilege the knowledge and status of the researcher over the interviewee (Smith, 1987), and this issue will be revisited later in this section.

### **Developing 'rapport'**

Both Oakley (1981) and Finch (1984) argue that women researchers share a subordinated position in a male-dominated society and that this may assist the development of trust with their respondents. Whilst remaining mindful of the need to avoid any exploitation of vulnerable interviewees, conscious efforts were made to establish *rapport*.

In providing guidance about the development of acceptance and *rapport*, Lofland (1984: 38) has advised that important and complementary methods comprise: '*absence of threat*', by being sensitive to the interview interaction and appropriate dress; and '*acceptable incompetence*', by demonstrating '*a quintessential student's role*', e.g. asking to learn about the influences on women's drug use. Mindful of Taylor's (1993: 13) discussion of '*impression management*' to promote acceptance, care was taken to dress informally or at least remove a jacket, which might be perceived as an emblem of masculine power. Taylor (1993) also noted Wax's (1979: 514) comment that '*the most advantageous and rewarding situation (for a researcher) is probably that of a mature woman*'. The suggestion that wider life experience can enable a greater breadth of empathy was encouraging, since a generation gap separated the researcher from the majority of her respondents. As an additional gesture, when interviews took place in GP surgeries or agency premises, women were encouraged to sit in the doctor's, or other professional's, chair and this handover of authority and expertise did not pass unnoticed by interviewees.

Furthermore, Maynard (1994) has commented that the personal involvement of the interviewer is an important element of establishing trust, and an interest in understanding more about local women's drug use was carefully explained. The importance that other researchers have ascribed to demonstrating respect and relying on gender as a common ground was also noted (Murphy & Rosenbaum,

1999). Guided by their example, and as a courtesy, refreshments were offered whenever possible, and accepted as a guest when in interviewees' homes. In response to her own questioning, some women asked about the researcher's own background: one interviewee apparently took it for granted that heroin use was a shared experience since drugs were a commonplace within her own community.

In particular, several women were interested in our shared status as mothers and those whose infants had spent time in the Special Care Baby Unit seemed reassured to know that this was an experience in common, although for the researcher many years previously. The women's vulnerability was often evident and it would have been unethical to exploit this in order to generate more data than they were ready to share. Frequently, they confided stories of harrowing and distressing experiences (Oakley, 1981; Renzetti & Lee, 1993) which needed a response of empathetic listening, as well as the supply of individual packs of tissues which were always available.

However, it is equally important to strive for an objective stance about the data generated, and to ensure that the tension between '*rapprochement*' and '*detachment*' is managed to enable methodical investigation (Glaser & Strauss, 1967). In this study, single interviews of between an hour and an hour and a half were the principal method, and this presented less opportunity for over-engagement as a result of full immersion in the drug-using sub-culture.

### **The Interview Process**

The interview process was organised in such a way that general questions based on the topic guide (Appendix A) about "*the story of your drug use*" were employed to provide a background. This also generated cues to develop this '*conversation with a purpose*' (Burgess, 1984: 102), and helped to create an atmosphere consistent with informality (Taylor & Bogdan, 1984). In due course, this also facilitated the more sensitive questions about personal behaviour, and the ease with which intimate information was disclosed was initially surprising.

None of the women was previously known to the researcher and it may be surmised that the social distance of acquaintance could have eased any discomfort of talking about personal matters, such as sexual or drug-using behaviour (Lee, 1993). It might also be argued that the environment was

influential upon this flow of information, since a doctor's surgery or agency premises may validate such disclosures. Finch (1984) has pointed out that personal information is frequently demanded of women and they are often subjected to intrusions into their private lives. However, some interviews took place in the women's homes and similar openness was demonstrated. In addition, interviewees sometimes spoke of past criminal activities, apart from the use of illegal drugs, and although none referred to current offences this provoked reflection on the '*consequence of knowing*' (Fitzgerald & Hamilton, 1996).

As the interview drew towards a close, efforts were made to discuss any goals or hopes for the future, in part to '*ground*' the discussion and to end the episode of more sensitive disclosures (Bowling, 2002). This prompted a range of responses from "*no future until I've got clean*" to more detailed descriptions of having a job, home, car and family, often summarised as being "*normal*". In practice, this closure seemed an important and positive aspect of the session for many interviewees, and some commented that only then had they fully realised the lifestyle changes they had already made.

The reflexive examination of practice became a fundamental part of the interview process: the sensitive nature of the topic focussed attention on issues around consent and expectations held by those who agree to be participants. Lee (1993) has pointed out that interviewees may not fully realise the implications of taking part, and that consent needs to be an ongoing process of checking that questions are not too intrusive. Generating disclosure of past trauma requires sensitivity on the part of the researcher in order to minimise the potential for ensuing distress. In this study, the opportunity to debrief after the interview frequently gave a chance to offer help-line details or signposting to other types of support. However, it seemed that the interview was not necessarily a detrimental experience, and a few women commented that they were glad to be able to articulate thoughts and feelings which had previously been reserved. The following excerpts provide some examples of interviewees' comments.

*Gemma, 28 years*

*"It's such a relief to get all this off my chest, I've never said this to anyone before."*

*Linda, 23 years*

*"I know I've really messed you around, not coming for appointments and that, and I can only apologise. I'm glad I've come - it's helped to talk about it all."*

Lara, 28 years

*"It's really helped me a lot, talking like this. I feel like a great weight has come off my shoulders. I hadn't realized how it had all built up inside me."*

Several other women expressed satisfaction at the opportunity to talk about their lives and spoke of the benefits of re-evaluating any progress in resolving their addiction. Five interviewees asked to make a further appointment, and the listening skills exercised in the research seemed to imply a therapeutic session. Further dates were arranged with two women, since childcare responsibilities had sometimes meant that the interview had to be curtailed before they felt they had fully shared their story.

### **The Dynamic of Power**

As the study progressed, it became evident that many interviewees' lives had been characterised by an imbalance of power and control, and several women recollected abusive situations. It seemed ethical and essential that the research dynamic should not replicate this situation but should enable women to *'have a voice'* and to recount their life experiences (Henwood & Pidgeon, 1995; Oakley, 1981). Conscious of this, as well as the fact that a common shared experience could not be presumed (Kelly *et al*, 1994), sensitivity to the research relationship was required. However, the qualitative method of in-depth interviews, which seek to generate detailed descriptions and affective responses, can in itself redress any imbalance, and privilege the power of the women's own words.

Nevertheless, with the passage of time, the extent to which equality in the research relationship could really be attained became problematic, as well as some doubt over Oakley's (1987: 66) claim that a shared structural position was in fact *'a magical device for the instant dissolution of inequalities'*. Kelly and colleagues (1994: 37) have pointed out that *'It is we who have the time, resources and skills to conduct methodical work, to make sense of experience and locate individuals in historic and social contexts. It is an illusion to think that, in anything short of participatory research project, participants can have equal knowledge to the researcher'*. However, the interviewee must be the expert of her own lived experience of becoming, maintaining and eventually rejecting an addict lifestyle, and will own her construction of social reality as well as any attached meanings. Furthermore, Benney and Hughes (1984) claim that equality in interviewing is principally defined by the aim of generating participatory dialogue

in the interviewee's own terms. It seems that it is collaboration rather than equality that can make interviewees' emotions, personal values and beliefs legitimate topics for study.

On the other hand, some commentators have argued that '*individuals do not necessarily possess sufficient knowledge to explain everything about their lives*' (Maynard & Purvis, 1994: 6). Accounts are always subject to memory and may be mediated by that and an individual's current social position, or in the case of drug users, their stage of recovery from addiction (McIntosh & McKeganey, 2000). Accounts do, nevertheless, indicate how individuals present themselves and routinely negotiate their social identities (Scott & Lyman, 1968). The role of the researcher may therefore be defined by the synthesis of a body of knowledge and conceptual frameworks, so that interviewees' accounts can be located in relation to those of the other participants. These narratives may then be interpreted and analysed within their social context, even though there may be little experiential common ground between researcher and those researched.

Reflection was also prompted by what Kelly and colleagues (1994: 37) term '*the troubling issue of what we do when our understandings and interpretations of women's accounts would either not be shared by some of them or represent a form of challenge to their perceptions, choices and coping strategies*'. The difficulties of making contact with women drug users will be discussed further in the following section, and this did compromise the chance of consulting on research findings with them. Following national policy, Cumbria Drug Action Team (DAT) has set up three Service Users' Groups in the county, and with perseverance a few women have now been recruited within the study area. Recently, an interim summary of research findings and recommendations was presented to Cumbria DAT and subsequently circulated to relevant groups, including the Service Users'. It was reassuring to receive the view from the coordinator of the group, that the interpretation of findings and recommendations for local policy and practice were regarded by members as "*spot on*".

### **Environmental influences on the research relationship**

One environmental influence on the research relationship which seemed to emerge was the high level of '*social communication*' between individuals within local communities, which has been said to be typical of non-urban settings (Scottish Drugs Forum, 1997). Moreover, Jamieson (1998: 86) has commented

that 'Urban settings provide more possibilities for creating social networks made up from separate and unconnected social worlds'. This meant that there could be a greater chance of familiarity between interviewer and interviewee, which might have the potential to interfere with the research relationship, as well as the disclosure of any sensitive information. However it is undoubtedly true that concerns about a similar situation could arise for researchers in any location.

Whilst neither the researcher's home nor social circles overlapped with interviewees', it was possible that they could meet at a future date for example, shopping in the supermarket or pharmacy, or buying fuel at the filling station. After consideration, it seemed wise for the researcher not to be the first to acknowledge acquaintance, but several women did greet her with news of their treatment progress, or of their families. The exception was a fellow patient in the waiting room of a doctor's surgery and this particular environment may have presented a dilemma for both. In North Cumbria, GP surgeries provide care for diverse practice populations, and are not situated specifically in areas of socio-economic disadvantage, from which the majority of this study group derived.

A further consideration related to the transcription of the audio-taped interviews and the researcher was concerned that any secretarial support might recognise voices, or guess by the places and names mentioned. As a result, these were all transcribed *verbatim* by the researcher to protect the women's identities.

In summary, assurances of confidentiality and anonymity in this type of non-urban setting are of particular significance, as well as an appropriate strategy for preventing unnecessary disclosures and for managing subsequent encounters with interviewees.

### **The difficulties of contacting a 'hard-to-reach' group**

It has often been noted that women drug users form a 'hard-to-reach' group whose views may seldom be heard (ACMD, 1998; Ettorre, 1992; Rosenbaum, 1981a; Taylor, 1993), and they may be particularly elusive if they have children (Bate, 2005; Gurdin & Patterson, 1987; Lex, 1991; NTA, 2002; Powis *et al*, 1997; Underhill, 1986). Renzetti and Lee (1993: 30) have pointed out that *'the more sensitive or threatening the topic under examination, the more difficult sampling is likely to be, because potential participants have greater need to hide their*

*involvement*'. This finding was corroborated by experiences of this study in North Cumbria and a great deal of perseverance was needed to contact a sample of female drug users. This section will now consider some of the factors which appeared to be influential.

Firstly, the covert nature of the women's substance use has been said to be governed by its illegality (Rosenbaum, 1981a; Taylor, 1993), and several interviewees had become involved in criminal activities such as shoplifting or drug-dealing to finance their dependence. Very few women acknowledged prostitution as a means of generating income, but the additional stigma attached to sex work can increase the need for concealment. It also seemed that the previously mentioned environmental issues of enhanced '*social communication*' (Scottish Drugs Forum, 1997) might have deterred drug-users' availability for interview. '*Higher visibility*' in non-urban settings can compromise a drug user's secret (Henderson, 1998; Mentor UK, 2004), and it has been suggested that this anxiety about identification may be more keenly felt by women and especially mothers (Ettorre, 1992; Rosenbaum, 1981a). Henderson (1998) quotes a comment by Holdaway and Davis (1996) on the implications of such a breach of confidentiality, '*Rural areas are like goldfish bowls, people (attending drug services locally) would be outcasts*'. However, it is possible that similar concerns could arise for researchers seeking study participants in any other location.

This leads on to a second factor which derives from the moral judgments which are frequently exacted upon women who use or misuse substances (Ettorre, 1992). There is a persistent perception of women's drug use as '*doubly deviant*' (Philip *et al*, 1997), or as '*polluted*' (Ettorre, 1989), and some have commented that they are '*doubly damned*' (Druglink, 2003). It appears that this stigma often results in low self-esteem (Griffin-Shelley, 1986; Reed, 1985), as well as women drug users' reluctance to be identified, which it has been said may render them more vulnerable (ACMD, 1998; Ettorre, 1992; Rosenbaum, 1981a; Taylor, 1993). Emotional distress may even be increased by the fact that many women drug users are said to retain traditional values and expectations of their feminine role (Cuskey *et al*, 1982; Rosenbaum, 1981a; Taylor, 1993). In particular, pregnant women and mothers will often avoid contact with services in case this results in statutory removal of their child on the grounds of safety or neglect (Bate, 2005; Broom & Stevens, 1991; Gurdin & Patterson, 1987; Lex, 1991; NTA, 2002; Powis

*et al*, 1997; Thom & Green 1996; Underhill, 1986). It has been remarked that this fear of losing care of any children can present a formidable barrier to coming forward for treatment, and its salience was emphasised by the majority of interviewees in this study, whether they were mothers or not (Ettorre, 1992; Hodgins *et al*, 1997; Swift *et al*, 1996; Taylor, 1993; Thom & Green, 1996). It may follow that an unknown researcher asking women to identify themselves as drug users will probably be regarded with similar suspicion.

A third factor influencing access to the study group seemed to be the social context of women's problem use which is frequently one of chaos, uncertainty and socio-economic disadvantage (Carlson, 1996; Taylor, 1993). The impact on women's physical and mental health of living in insecure accommodation, with unsupportive relationships and the tensions of crime and anti-social behaviour, has already been identified (Crossan & Amos, 1994; Graham, 1993; Payne, 1991). This instability means that accessing women to arrange an interview could become particularly challenging, since telephone numbers often changed constantly, and different but more pressing priorities inevitably prevailed.

### **Sampling strategy in this study**

The strategies of those researchers who have achieved samples of similar '*hard to reach*' groups, were reviewed for relevance to this study. These included: network development; finding a sponsor; attending locations frequented by drug users; and providing a service to the sample population.

Amongst them, the use of '*snowball*' techniques, in order to access networks of friends, is often advocated (Biernacki & Waldorf, 1981; Sudman *et al*, 1988; Sudman & Kalton, 1986). On the other hand, Lee (1993) cautions against developing a homogeneous sample and recommends limiting this chain to avoid the bias of accessing participants who all share the same attitudes, values and beliefs. Both Taylor (1993) in Glasgow and Rosenbaum (1981a) in San Francisco successfully used this method, with the latter also using advertisements to encourage participation in the research, as well as offering payment.

Offering payment to take part in research studies can become a complex and controversial issue (McKeganey, 2001), since it may introduce bias into the research relationship, or oblige a participant to engage beyond their own desires.

On the other hand, it has been argued that interviewees deserve recompense for inconvenience, although the amount must '*neither be an inducement nor a tokenistic gesture*' (Ritter *et al*, 2003: 2). Other commentators have advanced a view that drug users' reasons for participation in research will not only be about financial gain (Fry & Dwyer, 2001). In this study, women were not offered payment but a small box of chocolates was offered after the interview. In this study, women said that they were "*happy if it would help other people*", and interviews were arranged for the women's convenience, and to coincide with any other commitments.

Other investigators have used '*privileged access interviewers*', who have gained the confidence of local drug users and can sponsor the researcher (Griffiths *et al*, 1993). As an example, Taylor (1993) availed herself of a cooperative and trusted detached outreach drugs worker to secure access to female drug users in her study area. '*Outcropping*' (Lee, 1993) or the seeking out of places where drug users tend to congregate has also been used to make contact in locations such as: drop-in centres (Taylor, 1993); community pharmacy-based needle exchanges (McKeganey & Barnard, 1992); or acute hospital emergency departments (Neale, 1999; 2002). Some researchers have chosen to undertake a quasi-service provider role in order to reach specific and vulnerable study populations (McKeganey & Barnard, 1996). In this latter study, with the agreement of health authorities and police, McKeganey and Barnard (1996) carried supplies of condoms, sterile injecting equipment, harm-reduction and help-line information for street-working prostitutes in the red-light district of Glasgow. This approach allowed the researchers to become familiar with the study population, and to develop sufficient '*rapport*' to ensure the women's cooperation, as well as to promote interviewees' health and welfare.

Reflecting on those studies which had successfully accessed female drug users, it was hoped that once a few interviews had been secured the women's social networks might yield further participants, but disappointingly none emerged. Where this contact might have been possible, it would have been unethical to reintroduce the woman to former drug-using circles. It appeared that this difficulty arose mainly because women were trying to isolate themselves from previous drug-using contacts; or because friends were already attending the

same service; or because the factors which kept women at a distance from services were also applied to a research interview.

Meeting with drug-users at the pharmacy-based needle exchanges was reviewed but rejected since these are either situated in large retail stores or in small shops unsuitable for conducting an interview. Pharmacists pointed out the speed of departure of local addicts once the transaction had been completed, and that the majority of drug users using the scheme was male. The absence of either detached outreach drug workers or Drop-in Centres was an immediate disadvantage, and Day Care services had not attracted any women drug users at this time.

However, sponsors could be identified amongst local service providers and contact was made with a wide range of agencies: drug and alcohol services in both the statutory and voluntary sector; primary care services (including health visitors, community midwives and GPs); housing providers; probation services; women's crisis services; Youth Offending Teams; social workers; Sure Start; YWCA; Connexions and many other services and groups for young people. Agencies' subsequent assistance was invaluable and appreciated: several staff meetings were attended to explain the purpose of the study and criteria for inclusion, and regular telephone contact was maintained to remind colleagues that participants were needed. This meeting became an opportune time to fully explain the nature of the study and what would be required of participants, since it emerged that many staff had little knowledge or experience of qualitative research. The session also provided a chance to explain that it was not necessary to select those who "*would interview well*" or had "*a story to tell*", since a full range of experiences was needed for the study (Kitzinger & Barbour, 1999).

Despite this effort, progress was slow and sporadic: it took four months to secure the first interview and two years to achieve thirty. Drug service staff explained that only a few women attended regularly: one related that of the forty eight drug users on her caseload only three were female, and that women tended to be more difficult to stabilise, often failing to return for repeat appointments. Other agencies depicted similar images of elusive women drug users, but with perseverance sessions were arranged, and colleagues assisted by either asking women for permission to pass on contact details, or by inviting the researcher to

a joint initial meeting. It seemed that the opportunity to meet personally and to explain to both the process of the proposed interview was much more successful and also allowed the woman time to consider consent before another visit. This explanatory session may emerge as an important point for other researchers, since Cumbria currently lacks a University and fewer studies of this type are carried out (Cumbren, 2004, personal communication). Furthermore, it seemed that initial personal contact with the women could help to reduce any anxieties about taking part in an unfamiliar interview.

### **Environmental influences on accessing the sample**

Nevertheless, meetings with female drug users failed to materialise on several occasions, and in a few instances this could involve a return journey of over a hundred miles. The topography of North Cumbria meant that interviewees were sometimes widely dispersed and it was rarely possible to combine two visits on the one occasion. Sometimes non-attendance was explained and reasons varied from: *"changed my mind"*; assaults; burglaries; and a house fire; to a child's, her partner's or her own illness; her own or partner's arrest; and in one case his suicide. These instances served to underline the complexity and adversity of the women's lives and the relative unimportance of attending for an interview with a stranger. However, the most common excuse for absence was claimed to be the fear of *"everyone knowing your business"*, so frequently articulated by interviewees about the public disclosure of drug use, and this will probably have increased suspicions of being involved in an unfamiliar research study. Henderson (1998) has remarked upon the way the *'higher visibility'* of individuals in non-urban settings can influence early identification of a drug user, as well as create heightened anxiety about drug-related incidents in the community. Nevertheless, it must be acknowledged that similar anxiety about identification as an illegal drug user may be equally experienced by any individual who is invited to participate in a research study.

In summary, these deliberations have identified methodological issues connected with the principles and philosophy on which this research into women's drug use in North Cumbria was based. It has also considered any prior assumptions about making contact with this particular group of individuals, and has indicated some of the ideas underlying the analysis of the women's narratives. Interviewees' accounts presented a degree of heterogeneity, but it was noted that

certain issues within the research relationship and efforts needed to access the sample, were consistent.

## **Chapter 1**

### **North Cumbria: The setting and the study participants**

This opening chapter will begin by providing an overview of the setting of North Cumbria, in order to describe the context in which this research was carried out. The second section will go on to outline the social characteristics of the women who participated in this study.

#### **North Cumbria: the context of the setting**

North Cumbria encompasses four local authority districts within the second largest county in England, and has a population of less than 315,000 (ONS, Census, 2001). It includes the outstandingly beautiful Lake District National Park but also contains some of the most deprived wards in the country, particularly in the towns and villages along the coastal fringe.

Poverty and isolation can also affect the more rural communities, exacerbated by few services and economic opportunities, as well as limited or absent public transport infrastructure. In addition, the full health impact of the recent Foot and Mouth epidemic in 2001 has still to be established, but adverse psycho-social sequelae have already been noted (Mort *et al*, 2005). The whole of North Cumbria has been identified as having areas where there is '*significant rural, economic and social disadvantage*' (DEFRA, 2004).

Demonstrable disadvantage including low income, unemployment and poor health has attracted government interventions such as Neighbourhood Renewal, Sports Action Zone and Sure Start, as well as support through European Union funding streams. In 1998, North Cumbria was granted Health Action Zone status on the basis of health inequalities in Allerdale and Copeland, some parts of the Carlisle district, and because of rural deprivation in Eden. Nevertheless, socio-economic deprivation and health inequalities persist and 33 Super Output Areas remain in the worst 20% in England, with some in Allerdale and Copeland (West Cumbria) in the worst 3% (ODPM, 2004). Deprivation is evident within the domain of Access to Services, where data indicate that one third of North

Cumbria sits within the worst quintile in England (ODPM, 2004). This factor has financial implications both for organisations striving to provide equitable and accessible local services, and for individuals in terms of the expenses incurred in travelling to treatment facilities.

The definition of this setting as non-urban is justified by applying Carstairs and Morris' (1991) calculations of Urban Rural Values. These measure population size, on a scale of 1 to 5, in a continuous urban block, with a score of 1 equating to a built-up area of one million. Characteristics of population dispersal in the county may therefore be described as non-urban.

Currently, Cumbria is the only county in the UK experiencing economic decline (Cumbria Strategic Partnership, 2004). In comparison with the recently extended European Union, only Berlin, one sub-division in each of the Czech Republic and Bulgaria, and parts of Romania can demonstrate a similar pattern. Across Cumbria, there are many families who survive on low incomes and in areas such as West Cumbria, '*worklessness*' has been described as '*markedly severe*' with a high percentage of Incapacity Benefit claimants, mainly in the more deprived communities (Cumbria Strategic Partnership, 2006). This '*hidden unemployment*' is juxtaposed with some manufacturing industry and the nuclear facility at BNFL Sellafield, which provides jobs for a skilled section of the workforce, although it is possible that even this will decrease significantly with the anticipated change of emphasis in the nuclear industry. Cumbria has lower than average levels of skills and qualifications at NVQ 3 and NVQ 4 compared with national averages, and employers claim that it is difficult to attract and retain graduates and specialist staff (Cumbria Strategic Partnership, 2006). Current plans for a University of Cumbria by 2008 intend to mitigate this detrimental influence, but the lack of an appropriate transport infrastructure still seriously impedes connectivity with other centres of population.

One impact of this economic reality is the trend towards the out-migration of those young people who are able to secure higher paid jobs elsewhere (Cumbria Strategic Partnership, 2004; YWCA, 2002). Some commentators maintain that in this type of setting, young people capable of high achievement must leave to make any career progress, and that this culture can affect the aspirations of those left behind (Gabriel, 2006; Jamieson, 2000). Stockdale (2002) has

identified four different groups of 'out-migrants' from this type of area: 'committed leavers' who are highly educated and leave to pursue a career; 'reluctant stayers', who are less well educated and are constrained by lack of skills and financial resources; 'reluctant leavers', who leave because of the lack of local opportunities; and 'committed stayers', whose strong sense of belonging to their local community outweighs the disadvantage of living there.

It has been argued that an important factor for some young people in non-urban areas is the need to travel up to 40% further than their urban counterparts to further education or employment (Social Exclusion Unit, 2004; 2005). In Cumbria, seeking a job can be particularly difficult for young people, due to recent declines in the traditional sources of employment in manufacturing industries or agriculture, and the trend towards a service-based economy (Canny, 2004; Social Exclusion Unit, 2004, 2005).

### **Deprivation and illegal drug use**

The complex relationship between deprivation and illegal drug use has been consistently noted (ACMD, 1998; Giggs *et al*, 1989; Frischer, 1995; Parker *et al*, 1988) but there has often been an assumption that this phenomenon is confined to urban areas (Dickerson & Stimson, 1995; Henderson, 1998). Recent research does indicate a relationship between population density and increased illegal drug use, as declared in the British Crime Survey (Aust & Condon, 2003). On the other hand, Forsyth and Barnard (1999) were able to demonstrate similar levels of drug use amongst young people in adjacent rural and urban communities in Scotland, and argued that socio-economic status did not determine all patterns of drug use, but problematic use was linked with disadvantage. Young (2002) has also commented on the close link between substance misuse and social exclusion, but pointed out that poverty does not directly cause addiction. Although the determinants of disadvantage are social, experience and response is at an individual level and an axiomatic link is not inevitable (Dale-Perera, 1998; Young, 2002). A study which examined the effects of social exclusion upon young people highlighted its complexity, heterogeneity and unpredictability (Johnston *et al*, 2000). Despite the prevalence of crime, illegal drugs and few opportunities, informal social networks sometimes helped disadvantaged young people to manage the structural constraints in their lives, although early adverse life experiences were often significant.

At the time of this study, estimates indicated that 509 problem drug users were in contact with treatment services in North Cumbria (Cumbria DAT, 2004). Less than one third of these were female and this proportion is consistent with national figures which are believed to indicate under-representation, since patterns of male and female drug use seem to be converging (Becker & Duffy, 2002; DH, 2000; EMCDDA, 2005). Despite its relatively isolated location, North Cumbria experiences the effects of problem drug use (Cumbria DAT, 2004; Donmall *et al* 2002) and prevalence by postcode area data indicate that this is particularly evident within its more disadvantaged communities (Khundakar *et al*, 2006).

The following section will now describe the social characteristics of the women drug users who kindly agreed to be interviewed.

### **The Study Participants: their social characteristics**

This section will provide a short profile of the study participants' social characteristics, which will help to depict the people within the place.

#### **The age range of the sample**

Interviewees' ages ranged between seventeen and forty-two years. It can be seen in Table 1 below that the majority was contained within the 20 to 25 age group. In Cumbria, Donmall and colleagues (2002) noted a tendency for drug users in contact with services to be younger than elsewhere in the North West Region. They proposed that this could indicate recent increases in the incidence of problem drug use, and note that figures may have been affected by variations in service provision, as well as by the stage of epidemic diffusion (Millar *et al*, 2001). Donmall and colleagues (2002) also remarked upon the tendency within Cumbria and Lancashire for more women drug users (39%) in contact with treatment services to be younger, under the age of 25, than their male counterparts (29%). Donmall and colleagues (2002) suggested that this could be explained by women trying to access treatment at an earlier age; that they had a shorter drug-using 'career'; or that older women may have been under-represented amongst both the treatment group, and the rest of the local drug-using population. Women's earlier approach to treatment services has been noted elsewhere (Beynon *et al*, 2001; Hser *et al*, 1987), but Anglin and colleagues

(1997) have also pointed out that women tend to have longer addiction 'careers'. Some commentators have suggested that this factor may be influenced by women's greater co-morbidity (Swift *et al*, 1996), and others have argued that if women drug users remain with addict partners they can take longer to resolve their addiction (Powis *et al*, 1996). Furthermore, it has been noted that there is an increasing trend towards earlier onset of problem drug use amongst young women (Ziberman *et al*, 2003), which may result in and explain earlier contact with services. Recent findings from the National Drug Treatment Monitoring System (NDTMS) indicate that in Cumbria the proportion of women drug users in contact with services aged under 25 years has remained significantly higher (40.88%) compared with older age groups, and all other areas of the region apart from Blackburn (Khundakar *et al*, 2006). The NDTMS report also revealed that the North West region had the highest proportion of drug users in contact with services, and that the majority was over thirty years of age, at 67.82%, with 45.56% in their thirties. Khundakar and colleagues (2006) comment that in the last four years there seems to have been an increase in the proportionate age of individuals in treatment, and suggest a trend towards an ageing drug-using treatment population. In Cumbria, the section with the highest proportion in contact with services was reported to be the 24-30 years age band (Khundakar *et al*, 2006), which may reflect the progress of the stage of epidemic diffusion previously alluded to by Donmall and colleagues (2002).

Table 1 Interviewees' age in years

16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45
3	13	7	2	4	1

### **Interviewees' drug-using status**

Recent National Drug Treatment Monitoring System (NDTMS) estimates of the increase over the last four years in numbers of drug users in contact with treatment services indicate a rise of 232.24% in Cumbria, with a prevalence of 7.17 per thousand of population. This compares, for example, with Cheshire where the increase was 85%, and where prevalence was 7.78% (Khundakar *et al*, 2006). The NDTMS report estimated the proportion of female drug users to be up to 28.24% across the North West Region, but in Cumbria it was suggested that this could now be as much as 32.71% (Khundakar *et al*, 2006).

All of the women interviewed described heroin use as the drug which had become problematic, although one interviewee identified recent difficulties with amphetamine use. Many had intermittently used other opiates or benzodiazepines when experimenting or when heroin supplies were restricted, and this poly-drug use is typical of clients of treatment services elsewhere (Gossop *et al*, 2000). This preference for heroin is representative of Cumbria (Khundakar *et al*, 2006), where 85% of problem drug users in contact with services select heroin as their drug of choice, 5% choose amphetamines and 2% cocaine (Cumbria DAT, 2004). The majority of interviewees had been or was using heroin several times daily and had become physically dependent. A range of stages in drug addiction careers was described: two women had used heroin or prescribed substitutes for over twenty years, while others had experienced problem drug use for less than two. All the interviewees who had experienced treatment for their addiction described a cycle of relapse and then new episodes of treatment. Several of the women were currently on substitute-prescribing treatment regimes, some were still using heroin and others claimed to have become 'drug-free'. This is illustrated in Table 2.

As interviews progressed, it became clear that interviewees used the term 'recovery' and even 'drug-free' in ways which reflected their own interpretation rather than any professional definition. In some cases, 'recovery' clearly meant breaking away from a chaotic drug users' lifestyle, and for other women 'drug-free' was linked with no longer using heroin but being satisfied by prescribed substitute medication. The following extract is typical of the latter group.

*Linda, 23 years*

*"compared to what I was doing I've recovered. It's brilliant to stick to only that (methadone) and have no more 'cos I mean there have been times when I've missed picking up my prescription and just used to have half a bag"*

The researcher was not in a position to test or verify interviewees' claims, and the women's perspective of the stage of their dependence and recovery has been described in this thesis, rather than a report of any clinical assessment. In only one instance, an interviewee claimed that she was no longer using any illicit substances or substitute medication, but she also reflected on her beliefs about the local community's perception of addiction and the possibility of recovery.

Lara, 28 years

*"I haven't used for a year now but I'm always going to be labelled a recovering addict, and people have to accept that it takes a lot of different sorts to make up this world. You can hide away or face it."*

Recent findings of the National Drug Treatment Monitoring System (NTDMS) show that in Cumbria 33.33% of drug users are discharged with 'treatment complete' but only 4.02% are 'treatment complete - drug-free'. This compares, for example, with Cheshire where 5.12% are 'treatment complete' but 12.2% are 'treatment complete - drug-free' (Khundakar *et al*, 2006).

Table 2 Interviewees' drug-using status

Using heroin	Using heroin and prescribed substitute medication	Using substitute medication, but not heroin	Using amphetamines	Using no illicit drugs
1	11	16	1	1

### **Interviewees' marital or civil status**

Drug use has been recognized as a socially-situated phenomenon (Bloor *et al*, 1992; Bloor, 1995; Bourgois *et al*, 1997; McKeganey & Barnard, 1992; Rhodes, 1997), and women drug users' pattern of consumption frequently involves relationships with male addicts (Davies *et al*, 1996; Dwyer *et al*, 1994; Gossop *et al*, 1994; McKeganey & Barnard, 1992; Powis *et al*, 1996). This finding resonates with women's accounts of their sexual relationships, since all but two had been in steady liaisons with a male counterpart at some stage. One of these women had never had a boyfriend before her current (non-addict) partner, and the other had separated from her partner (non-addict) because he strongly disapproved of her disclosure of drug-taking, and she reported only having had casual relationships since. It appeared that interviewees' addict relationships were sometimes in series, others were long-term and some interviewees had been or were married to an addict. The British Crime Survey (Aust & Condon, 2003) indicated that in general, single people are the most likely to use illegal drugs, followed by those cohabiting, with married and widowed people less likely to use drugs.

The marital (Table 3) or civil (Table 4) status of interviewees is set out at the bottom of this section. It can be seen that eight of the women had been married to addicts at some time, but interviewees said that four relationships had ended for drug-related reasons. It was explained that interviewees had divorced or separated from their partners because of dissatisfaction with his behaviour, such as unfair and unequal sharing of heroin supplies; or because of disparity in 'readiness' to cease drug use (Rosenbaum & Murphy, 1984); and some women also said that they now wanted independent control of their own lives. Similar reasons for terminating relationships were presented by those women who had cohabited with male addicts, but some of these interviewees also indicated that domestic abuse had become intolerable and they had eventually parted. Several women now described themselves as single, and said that they intended to remain so while they were undertaking drug treatment.

Only three women were currently living with a non-addict, two of whom knew of her heroin use and the other remained in ignorance. The other two women who had ever lived with a non-drug-user claimed that either disclosure of her addiction, or suspicion on behalf of this partner that she had resumed heroin use had ended their relationships. As Rhodes and Quirk (1998: 160) remarked: *'Relationships are themselves a form of risk management made complicated by drug use'*.

Table 3 Interviewees' marital status

Ever married drug user	Currently married drug user	Ever married non-drug user	Currently married non drug user
8	4	0	0

Table 4 Interviewees' civil status

Ever cohabit male Drug user	Currently cohabit male drug user	Ever cohabit male non -drug user	Currently Cohabit male non-drug user	Single
24	6	5	3	17

### **Interviewees' parental status**

A recent inquiry into the needs of children of problem drug users indicated that up to 300,000 children in England and Wales may live in homes with drug-using parents (ACMD, 2003). It has been estimated that only 37% of fathers and 64% of mothers from such families live with their children, who were often cared for by grandparents (Meier *et al* 2004). More than half of the women in this study were mothers (18: 30) and two interviewees were nearly six months pregnant. Table 5 reveals the variation in the situation for these mothers and children. Eleven women were currently living with their children and eight of those had never lost custody of them. Eight sets of grandparents had intervened at some point to care for children for varying lengths of time, and two had gained official custody. Three non-addict fathers were taking care of their children to ensure that they could remain within familiar surroundings; but two women's children were in temporary foster care and one woman's first baby had been adopted.

Table 5 Interviewees' parental status

Mothers	Pregnancy confirmed	Currently living with children	Grandparents gained custody	Temporary foster care arranged	Father gained custody	Ever had children adopted
18	2	11	2	2	3	1

### **Interviewees' current living arrangements**

Interviewees described circumstances which were characterised by poor social, physical and economic living conditions: this is in common with the findings of many other studies (ACMD, 2003; McKegancy & Barnard 1992; Parker *et al*, 1998; Pearson, 1987; Stimson, 1987). The women's domestic situations varied, with some interviewees living with a partner or husband, although several relationships had now been terminated, and sometimes women had lived with a series of addict partners. A number of women had returned to live with their families of origin, hoping that this would help to protect them from drug-related temptations, by virtue of the change of environment. It seemed that in many cases, parents insisted that she returned to the family home, in order to restore her general health. Some women had chosen to live alone, sometimes because they had become estranged from their families. Two women lived in Supported Housing accommodation, and two interviewees were staying in a residential

rehabilitation unit at the time of the study. None of the women said she was homeless, but one interviewee was anxious that her private tenancy was coming to an end, and knew that she would now be excluded from social housing allocation lists. This was said to be because a drug-dealer boyfriend, who had moved in to her rented flat, had recently received a substantial custodial sentence, and she was now culpable for his actions.

Table 6 Interviewees' current living arrangements

Living with partner	Living with husband	Returned to family of origin	Living alone	Drug rehab. unit	Supported Housing scheme
8	4	10	4	2	2

### Interviewees' educational attainment

The level of educational qualifications possessed by an individual may be seen to represent their potential life chances: higher attainment can provide the chance and choice of more secure and higher paid employment. Census data (ONS, 2003) indicated that North Cumbria had higher levels of people without formal qualifications than South Cumbria and other parts of the North West region, and this was most evident in West Cumbria (Allerdale and Copeland districts), which sat in the second lowest quintile. This is significant because those who fail to achieve at school are likely to be limited in their choice of jobs (Shucksmith, 2004), which further contributes to the social exclusion which divides young people and mediates the type of opportunities available to them (Jamieson, 2000). Furthermore, Jamieson (2000) has argued that there is considerable affiliation between social class and educational attainment, and that the agency of some young people continues to be restricted by their qualifications.

In the North West Region, the number of young people gaining Level 2 qualifications (5 GCSE grade A – C) has been shown to be lower than the rest of England (DfES, 2006), and it has been said that employers regard Level 2 as a proxy for generic skills and the possibility of career progression (Green & Owen, 2006). In Cumbria, it has been demonstrated that young people's post-17 engagement in education is also lower than the national average (DfES, 2006), and in similar areas this has been linked with low career aspirations (O'Hanlon,

*et al*, 2001). McGrath and colleagues (2006) have asserted that poor educational attainment or even academic failure, can be predictive of early initiation into problem drug use. Table 7 indicates the qualifications which interviewees said they held. Interviewees' lack of qualifications was often explained by accounts of truancy, bullying or other disruptive influences and disaffection in early adolescence. The three women who had gone on to achieve higher education qualifications had gained them in catering, secretarial work and languages. In their narratives, it became clear that these women perceived that having qualifications provided evidence of ability, and greater hope of employability and re-establishing non-drug-using careers.

Table 7 Interviewees' educational attainment

Level 2 qualifications	Higher education qualifications	No qualifications
4	3	26

### **Interviewees' employment status**

It has already been noted that currently Cumbria is the only county in the UK experiencing economic decline, and that indicators of average productivity are low (Cumbria Strategic Partnership, 2004; DEFRA, 2004). However, recent partnership initiatives have tried to create an environment where increased inward investment may promote employment opportunities and economic recovery (Cumbria Strategic Partnership, 2006). Cumbria experiences disadvantage due to its relative isolation and remoteness from other population centres, underscored by limited transport infrastructure. This means that individuals and communities do not benefit from proximity to the large urban centres in the North West Region which might have employment opportunities.

The pattern of high long-term male and female unemployment is particularly evident in West Cumbria and Carlisle District, which has implications for people's lives and the economic vitality of the area (ONS Census, 2003).

Unemployment, or disengagement from the formal labour market by those of working age, may therefore be affected by lack of skills or job opportunities, and is likely to impact on material as well as social well-being through potentially restricted networks (Midgely *et al*, 2003).

Interviewees' pattern of unemployment, as described in Table 8, may be seen to reflect the lack of educational attainment previously described in Table 7. The majority of drug users tend to be unemployed (ACMD, 2003; McKeganey & Barnard, 1992; Parker *et al*, 1998; Pearson, 1987; Stimson, 1987), and very few of the women in this study said they were currently working. Amongst those employees included: a garage shop assistant; a cleaner; a prostitute; and a personal care assistant. A number of women had been employed in temporary low-paid occupations, but one had been a secretary and another two had worked in catering services. Several women mentioned that an ideal was to resolve their drug dependence and find a job, as part of regaining a "normal" life. McIntosh and McKeganey (2001) have argued that training and skills development are essential to re-entry into the job market, which is central to the process of recovery from addiction and increased social inclusion. Those interviewees who desired employment often mentioned the current barriers which faced them such as: low skills in literacy and numeracy; the implications of having a criminal record; and the practical difficulties of accommodating the daily collection of methadone supplies. Other women claimed to have no such aspirations for employment and it has been said that economic decline in West Cumbria has become part of 'the collective psyche' of the local population (West Cumbria Strategic Partnership, 2006).

Table 8 Interviewees' employment status

Never worked	Ever had a job	Currently working	Would like to have a job	No aspirations to have a job
18	8	4	20	6

## Chapter 2

### The Women's Initiation into Problem Drug Use

This chapter will focus on the initiation of women's problem drug use in North Cumbria and will account for what interviewees said about any influences involved, including their own role. Contributory factors which the women rated as significant included susceptibility, curiosity and trust and these will be discussed, as well as a range of social circumstances. It will begin by reviewing the sociological literature on initiation and of women's addiction, and will also consider what is known about early drug use in North Cumbria.

#### Initiation into problem drug use

A consideration of the sociological literature on initiation into drug use must refer to Becker (1953) who sought to dispel the notion of predisposition to addiction and to promote the influence of social experiences. Located in the symbolic interactionist tradition, he asserted that to cross the '*invitational edge*' to involvement required '*intention*' or '*willingness*' and a '*conscious*' decision to become initiated, but that social circumstances could determine an individual's attitudes and receptiveness. He later applied Goffman's (1959) idea of a '*deviant career*' in order to understand the processes involved in becoming an addict (Becker, 1963). In a similar fashion to legitimate careers, a drug-user may be seen to pass through a number of stages and to adopt a sense of identity and self-esteem through accomplishing the '*business*'. In '*labelling theory*', ascribing an individual '*deviant*' by third parties served to accentuate that addicted status: Lemert (1951) considered that '*primary deviants*', who were experimenting but not yet self-categorised as problematic may, by external affirmation, change their self-perception to become '*secondary deviants*' and thus initiated and subsumed in, for example, problem drug use.

More recent analyses have proposed theories of social action, in which risk behaviour, including initiation, is seen to be the product of interaction (Rhodes, 1997). It has been posited that social interactions rather than individuals '*do a*

*large part of the perceptual coding on risk*' (Douglas, 1986). Recently, Monaghan (2001) has taken a phenomenological approach but argues that this is compatible with a social cognition theory of risk perception (Bloor, 1995). He expounds the view that an individual's knowledge and attitude to risk will be influenced by a '*system of relevances*' (Schutz, 1970), along with their degree of integration into a deviant population with similar cultural viewpoints (Wight, 1999). This corroborates previous applications of Schutz's schema to risk behaviour, which explained some of the constraints and influences of the social context (Bloor *et al*, 1992; McKeganey & Barnard, 1992).

The earlier theoretical frameworks were applied exclusively to male drug users, and analyses of women's initiation and addiction were generally neglected (Ettorre, 1992; Pettitway, 1997; Rosenbaum, 1981a; Taylor, 1993). Rosenbaum (1981a) argued that women confronted different social pressures and different circumstances, but that the '*career*' model was relevant and indeed preferable since it was non-judgemental and diverted existing notions of individual female psycho-pathology. In terms of women's initiation into drug use, she emphasised the significance of the '*social world*' (Lindesmith *et al*, 1977) and its '*shared symbolisation, experiences and interests*', believing that this laid the foundation for addiction. Lcx (1991) explained this paucity of research into female addiction as being due to perceptions of a minority population sharing similar characteristics as male counterparts, and to women's complex psycho-pathology confounding study.

The reasons for women's initiation into problem drug use remain controversial but appear to be significantly different from their male counterparts. In particular, research on women's initiation reveals that while most men begin their drug use with other men, the opposite applies to women (Ettorre, 1992; Powis *et al*, 1996; Rosenbaum, 1981a; Suffet & Brotman, 1976; Taylor, 1993). One explanation, which has become the conventional view, is that they are pressured to participate by men, usually their sexual partners (Anglin *et al*, 1987; Nurco *et al*, 1982; Reed, 1985) and women drug users have often been described as '*passive and immature*' (Bury, 1992). On the other hand, Maher (1995; 1997), Rosenbaum (1981a), and Taylor (1993) argued that their interviewees in New York, San Francisco and Glasgow respectively, were actively involved and keen to experience the effects of heroin for themselves.

Furthermore, Ettorre (1989; 1992; 1994), Henderson (1993; 1997; 1999) and Measham (2002) have recognised and asserted the need for a feminist perspective, rejecting notions of women as passive objects of power and replacing this with images of agency and of empowered individuals using substances to seek pleasure or to cope with oppressive situations.

The data generated by this study present a multiplicity of reasons which elaborate the assertion of purposeful participants. Rebellion against accepted norms of feminine behaviour, as well as attempts to emulate male partners, frequently occurred in the women's narratives, thus challenging the stereotype of passivity. Moreover, interviewees' accounts of their partners' reaction to the discovery of their problem drug use counteract the view of male persuasive or oppressive influence.

### **Early drug use and susceptibility in Cumbria**

Surveys of health-related behaviours, including substance misuse, have been carried out regularly in a selection of Cumbrian schools since 1988. This has permitted a review of trends as well as comparison with data from a national reference sample of schools' data. The most recent survey indicates a five-fold increase since 1990 for the Year 10 (pupils aged 15 years) in '*knowing a drug user*' and therefore potential proximity to a source of supply (Balding, 2004). The following data, in Tables 9, 10, and 11, indicate students' drug and alcohol use and suggest increased risk behaviour of some young women in Cumbria, compared with counterparts elsewhere in the country (Balding, 2004).

Percentage who claim to have taken an illegal drug, not cannabis, within the last month

Table 9

	Cumbria Schools	National reference sample
Boys Yr 10	14%	18%
Girls Yr 10	27%	17%

Percentage who claim to have taken alcohol and a drug on the same occasion

Table 10

	Cumbria schools	National reference sample
Boys Yr 10	16%	18%
Girls Yr 10	28%	19%

Percentage responding that they could buy alcohol in a pub or bar

Table 11

	Cumbria Schools	National reference sample
Boys Yr 10	18%	8%
Girls Yr 10	25%	9%

(Balding, 2004)

It may therefore be seen that although Cumbria is a relatively isolated area, many young people may be exposed to early drug-trying. The concomitant pattern of regular underage drinking (Balding, 2004) may indicate a common predisposition to risk-taking and a social environment where they are vulnerable to early initiation (Chassin *et al*, 2002; Coleman & Cater, 2005; Lynskey *et al*, 1998).

Findings from another longitudinal study of young people in the North of England, have corroborated the Cumbrian schools' data and have proposed that drug use in the region is characterised by earlier onset and continued prevalence (Aldridge *et al*, 1999). Others have commented that these factors can predict patterns of sustained drug use and the likelihood of related problems (McKeganey & Norrie, 1999; Lloyd, 1998). Nevertheless, many young people manage to resist becoming regular users, with less than 10% of them developing problems (Parker *et al*, 1995), and illegal drugs become part of the risk-taking integral to the process of maturation.

This pattern of early onset was confirmed by most (26: 30) of the women interviewed for this study. They reported first use in early teenage years, but most explained that this had usually involved cannabis, ecstasy and other drugs perceived to be less potent. Furthermore, they were at pains to differentiate between this and subsequent encounters with substances which became problematic. However, a few had tried heroin as young as eleven years old and said that this was linked to witnessing drug-taking by older associates, although none implied that she had been coerced. The importance of social interaction in the early stages of drug use has been recognised (Kandel, 1974), and friends often provided the supply chain (McArdle *et al*, 2002). Initially, heroin could induce nausea, but interviewees explained that with perseverance it became a rewarding experience which reinforced further use (Boys *et al*, 1999). Women

recollected a sense of the drug rushing through the body with a pleasant relaxing effect and bringing feelings of warmth and emotional insulation from any problems.

Certain social characteristics are known to increase vulnerability to early onset of problem drug use and these '*at risk*' groups include: truants or school excludees; young offenders; young homeless; runaways; children from substance-using families; sex workers; and '*looked after*' young people (Canning *et al*, 2004; HAS, 1996; Gilvarry, 1998; Goulden & Sondhi, 2001; Powis *et al*, 1998). The Youth Lifestyles Survey 1998/1999 (Goulden & Sondhi, 2001), which carried out a secondary analysis of research into drug use by these vulnerable groups, indicated that female truants and excludees tended to have higher prevalence than their male counterparts for most types of drugs. This study also confirmed that there was a disproportionate prevalence of problematic drug use amongst young people who were deemed vulnerable and thus '*at risk*'. Predictors of initiation by vulnerable young people included: socio-economic deprivation; neighbourhoods where crime or unemployment is prevalent; family history of substance misuse; academic failure; and other social influences (McGrath *et al*, 2006). It has been argued that the 11-14 age groups may be at particular risk of drug experimentation, when the context is progressive disaffection from school and low parental supervision (Hammersley *et al*, 2003). Furthermore, young women within these '*at risk*' groups were noted to be vulnerable to particularly complex and serious problematic drug use (Hammersley *et al*, 2003; Melrose & Brodie, 2000).

Many interviewees (19: 30) accounted for their susceptibility to early drug problems, and one was Jade, now a prostitute, who had truanted from school and had run away from her adoptive family before she was twelve. She lived with disaffected older adolescents and managed to evade all contact with Education and Social Services until arrested for shoplifting more than four years later. Cusick and colleagues (2003) have argued that the majority of young sex workers begin problem drug use before prostitution, and that sex work and drug use can be mutually reinforcing. They suggest that a number of factors can interact to '*trap*' young people who are made more vulnerable by: becoming involved in prostitution or problem drug use before 18 years; street sex work; and being either homeless or in local authority care (Cusick *et al*, 2003). In the

following extract, Jade explains the influence of older peers on her initiation into heroin and the impact of witnessing their drug-taking.

*Jade, 18 years*

*"Well, I've used heroin since I was 12. One day, me and my friend just decided we'd get a bag of it (heroin) between us. We'd seen other people doing it, so we knew what to do and it just went on from there. She was older than me, and it was easier for her to get hold of it".*

Several women (12: 30) disclosed physical or sexual childhood abuse, which was not mutually exclusive, and said that this had made them feel rebellious, angry or depressed, linking that with early onset. Some estimates suggest that up to 70% of women's substance misuse can be linked with early experiences of violence, often sexual assault, which becomes a significant trauma (Roth, 1991; Russell & Wilsnack, 1991; Vogt, 1998; Wilson, 1997). Sara had been subject to repeated beatings by her father and said that this had led to local authority care where her problem drug use began, and she was convinced that these episodes had made her susceptible. In this extract, she indicated the impact of strained family dynamics as a structural influence on her early drug-taking, as well as her own guilt about the outcome of her father's violence.

*Sara, 26 years*

*"Partly my mum getting ill and my dad getting stressed out and me and my sister playing up and my dad was hitting us both. One day he grabbed me round the throat, so tight, it went completely black. And my dad said it was my sister, and my sister said it was her that done it. And I had to go home and get a hiding that night for telling. So I put myself in care. (Tears) She said I shouldn't have told outside the family, and it was my fault, sort of thing".*

Melrose and Brodic (2000) found that young women experiencing similar situations overtook young men in their substance use, and that this began earlier and became more problematic. Women drug users tend to report higher levels of family dysfunction (Holsten, 1985; Robbins, 1989) and personal issues arising from childhood abuse (Copeland & Hall, 1992). Paradoxically, substance use is often a precursor to mental health problems and even suicide (Gilvarry, 2000). Lloyd (1998) has described a 'web of causation' linking these risk factors for early onset and escalation of drug use amongst troubled adolescents. Interviewees indicated that parental substance use could be central to these determinants: some women (6: 30) recalled alcoholism and in one case, heroin

addiction. It has been noted elsewhere that drug-using women may be more likely to have a substance-dependent mother (Neale, 2004).

This section has indicated some of the influences that the women believed had increased their susceptibility to early drug use. However interviewees were all keen to state that a personal choice had been made to try heroin. Additional influences on this choice were said to have been curiosity and trust and the following two sections will account for their impact.

### **Interviewees' curiosity about the effects of drugs**

All of the women (30: 30) selected curiosity as an important factor in their initiation, although it is probable that this will also apply to their male counterparts. More specifically, they were intrigued by its effects and said that this was often tempered by a partner's drug use and the desire to comply with the expectations of peers and siblings, as well as by their own personal attributes. Curiosity was sustained and could even be intensified when close relatives or friends had died of heroin overdose: a few women (3: 30) said that they had *"wondered what could have been worth that much?"*

Nearly all interviewees had lived with a male drug user (28: 30) and curiosity was often said to have been accentuated by the desire to emulate his drug use. In San Francisco, Rosenbaum (1981a) described women resenting expenditure on goods coming in to the household, in particular heroin, which they did not share. This seemed to be less of an issue in North Cumbria, and Jan's account is typical of those interviewees (26: 30) who asserted their right to enjoy heroin's euphoric effects for themselves. Ettorre (1989: 108) has argued that for drug-using women, pleasure as *'a deep sense of personal and social satisfaction based on psychological and physical well-being'* is often non-existent in their lives, and that to seek it is clearly linked with the notion of empowerment.

*Jan, 30 years*

*"Well, I thought, I want to know what it feels like and if he (partner) could do it then so could I. And it was great, we'd get a bag of it and drive out to the Lake District at the weekend and sit on a hillside together and have a few hits".*

It seemed that the presence of a drug-using partner frequently results in an escalation of heroin use (Hser *et al*, 1987; Klee, 1996) and several studies have

noted women drug users' tendency to establish addict relationships and to adopt his pattern of use (Gossop *et al*, 1994; Klee, 1993; Klee, *et al*, 1990; McKeganey & Barnard, 1992; Powis *et al*, 1996). Once addicted, women's drug use often equates with men's (Almog *et al*, 1993; Anglin *et al*, 1987) but it can become 'telescoped', permitting rapid development of drug-related health problems (Lex, 1991; Powis *et al*, 1996; Rosenbaum, 1981a). Proximity to heroin means that curiosity can be more easily and regularly satisfied, and Cuskey (1982) has remarked that an addicted male companion is the greatest predisposing factor for female drug use.

Some interviewees (4: 30) commented resentfully that their youth or status as single mothers afforded them priority for local authority accommodation, and that their drug-dealer partners had exploited this. Other women affirmed that living with an addict meant there were opportunities to develop the necessary skills and a fascination with the effects of heroin use. Elaine confessed that her interest in Alex was increased by his perceived 'cachet' as a heroin-user boyfriend, but that she was naïve about the power of addiction. This extract provides some insight into the role of an addict partner and his circle of friends.

*Elaine, 24 years*

*"I think for me, it was a conscious decision: I didn't just fall into it. I was intrigued about it, curious, wanted to find out what it was like. My boyfriend Alex was a heroin addict, and his friends were, too. They introduced me to it. I was interested in it already but they, he brought it close to me".*

Rosenbaum and Murphy (1990) have proposed that some women may begin drug use to counteract tedium and depression and thus the euphoric effects of heroin may appeal at times when they are particularly vulnerable. Early motherhood can be a stressful time for all women (Cowan & Cowan, 1995; Phoenix *et al*, 1991; Small *et al*, 1994), depression is common and risk factors include the lack of a supportive partner (Brown & Harris, 1978). In addition, Finnegan (1988) has identified significantly higher levels of depression (75%: 50%) amongst drug users attending an ante-natal clinic. Thompson (2004) has pointed out that chronic stressors, such as housing and financial problems, substance misuse, domestic abuse and inadequate social support, are linked with increased rates of depression in pregnant women, and that this can increase the risk of premature birth. Taylor (1993) and Boyd (1999) both found that male partners of female drug users were unhelpful during pregnancy and

early motherhood, but Klee (2002) argues that this may depend more on other issues such as social class, culture and degree of male drug dependence. A body of research on smoking has already illustrated how women employ legal substances to manage the stresses and strains of motherhood and economic deprivation (Crossan & Amos, 1994; Graham, 1984, 1993; Payne, 1991). In the following extract, Brenda, now a mother of five, partly attributed her initiation to similar pressures, and claimed that witnessing heroin-induced oblivion had stimulated her desire for respite.

*Brenda, 28 years*

*"One day, my ex-partner came in with this lad, a heroin addict and a dealer, and they were smoking it in front of us, and I was just dead curious, because they looked so peaceful, not a care in the world, and I was desperate to feel like that. Take away all my problems. Life was hard, Sean (former partner) wouldn't even take the kids out. I had everything to do."*

On the other hand, some interviewees (6: 30) began their heroin careers with female friends and Kitty was influenced by someone who had the personal attributes she craved herself. In the following extract, she explains that emulating a self-confident friend, whom she had watched using heroin, was an important influence. In Glasgow, Taylor (1993) found that other women were often involved in first drug-trying but noted that it was men who subsequently introduced women to problematic drugs.

*Kitty, 28 years*

*"I wanted to but I was frightened to, if you know what I mean. I watched her (friend) do it and eventually I had some off her. She was actually younger than me but she'd always been a tearaway, bit of a tomboy whatever. Very sure of herself and I kind of wanted to be like that too, I suppose. We were mates."*

Women drug users often report low self-esteem and several commentators assert that conflict between attitudes, lifestyle and social stigma may be influential upon their sense of worth (Griffin-Sholley, 1986; Kline, 1996; Reed, 1985; Swift *et al.*, 1996). It has been noted that some women admit shame that they have deviated from the expected societal norm (Ettorre, 1992), including expectations of their caring role as mothers (Broom & Stevens, 1991; Mondanaro, 1989).

Several interviewees (11: 30) talked about personal traits which affected curiosity and their first use of heroin. Attributes such as being either: easily persuaded; sensation-seeking; impulsive; socially ambitious; or fearing loneliness all

mediated curiosity and the prospect of pleasure. One such example was Sara who had recently left home for University, and had delighted in overtaking her local friends by using heroin with her new addict boyfriend.

*Sara, 26 years*

*"In the beginning it was kind of smart because not many people were doing it – I'm talking seven or eight years ago. Now it's everywhere. I felt like I was a bit ahead, using heroin with my man, other people weren't there yet."*

The recognition that drug use *"was everywhere"* and *"in your face all day"* was frequently mentioned (26: 30) by interviewees as a justification for initiation. The accommodation of drug use, the so-called '*normalisation thesis*' argues that this phenomenon is now embraced by groups, including women, who were previously not engaged in drugs subcultures (Parker *et al*, 1998). South (1999: 4) has accounted for this powerful influence of widespread illegal drug use in some communities as '*part of the paramount reality of everyday life*'.

### **Interviewees explanations of trust**

Trust in the individual who was encouraging or enabling initiation was often identified by interviewees (27: 30) as essential to progress interest into actually trying heroin. Sometimes (3: 30) this could be a family member (Davis & Dinitto, 1996), such as Jo's drug dealer brother who offered heroin to ease her distress and insomnia after discovering her long-term partner's infidelity.

More frequently (22: 30), a sexual partner said to be pivotal, which resonates with the findings of other studies, and trust in him was unanimously selected as being of paramount importance (MacRae & Aalto, 2000; Rhodes & Quirk, 1998). Giddens (1991) has declared that basic trust is crucial to the development of relationships, and gives meaning to certain personal and social activities: it was evident that interviewees applied this sentiment to their initiation. In this extract, Alison explains that implicit trust in her husband had validated her drug-trying, such that she did not question its effects or her personal safety.

*Alison, 36 years*

*"Well I was so ignorant – I didn't know about the withdrawals and all that – I didn't know it was a different thing. And he was my husband so I trusted him to know about these things –so if he said 'Here have some of this', I took it. He said I would feel nice and that."*

Contemporary research has recognised drug use as a socially-embedded phenomenon (Bloor, 19995; Bourgois *et al*, 1997; McKeganey & Barnard, 1992; Rhodes, 1997) and those interviewees (28: 30) who had ever had an addict partner affirmed that sexual relationships were important to their dependence. They spoke of a range of features which made this drug-using dyad so influential including: his notoriety and expertise; as well a desire for affinity; and to share the experience of intoxication.

It was evident that a drug-using partner even had appeal, status and attraction for some women (8: 30) and several accounts revealed how this could draw women towards initiation. A few interviewees (3: 28) claimed that their involvement was linked with a belief that they could help a heroin-user resolve his addiction. This care-giving role is conventionally a gendered one and Klee (1996) has pointed out that women in drug-using relationships face similar obligations. Socialisation means that women's self-identity and sense of worth is often contingent on their nurturing role and thus being '*depended upon*' (Ettorre, 1992).

The functional effects of opiates were initially appreciated and a few women (4: 28) said they hoped that this might enhance their romance, by reducing tension and easing conversation. For some couples using heroin together did provide a focus of mutual interest, and Carol reflected on its influence within her marriage. She intimated that using drugs had assumed meanings of closeness fundamental to this type of relationship.

*Carol, 42 years*

*"It sort of gelled it once I was into it I suppose. This was the one area where we (Carol and husband) could be very open with each other. I think that using drugs was a kind of intimacy. If you're using heroin there isn't much of a sex life. We shared well a sort of intimacy in just sitting around and using our drugs together."*

The majority of interviewees' addict relationships (18: 28) was characterised by an age gap of between five and sixteen years less than their partners. The greater life and drug-using experience of the men was rated as conveying both dependability and superior authority. On the other hand, it has been noted that recently initiated female IDU appear to be more susceptible to hepatitis or HIV, although no apparent gender differences in risk behaviour can be identified (Des Jarlais *et al*, 1999; Garfein *et al*, 1996; Fennema *et al*, 1997), except that their

older male IDU partners may have had regular exposure to blood-borne infections (Anglin *et al*, 1987; Hser *et al*, 1987).

Several women (8: 28) now declared some insight into the male manipulation that had increased their problematic drug use, and had dissociated themselves in efforts to recover from addiction. As initiation progresses into a stage of 'inundation' (Rosenbaum, 1981a), women's emotional dependence on their addict partners has been said to increase (Klee *et al*, 1990) and they may then be less inclined to acknowledge betrayal of trust. Sara averred that her sixteen years senior addict boyfriend had ensured the continued development of her dependence on heroin, and then began to inflict systematic abuse. Nevertheless, she retained ownership of the decision to try heroin. In this extract, she confided the fears of the unknown which were assuaged by trust in her partner's traditional protective role.

*Sara, 26 years*

*"But he'd only give me a bit, just enough to keep me wanting it. He controlled it all. If it's drugs you've never done before you feel a bit frightened – a terrible rush that you can't handle, or you might die or something. Because it was the guy I loved, trusted, it gave me the courage to have a go."*

The transition to intravenous use, for nearly all (23: 26) of the women, involved a male presence and he usually administered (23: 26) the first injection, as has been reported elsewhere (Barnard, 1993; Klee *et al*, 1993; Powis *et al* 1996). Young women seemed to be particularly vulnerable and Sue was convinced this had eased her initiation, although experience of drug dependence and subsequently prostitution had changed her perspective. In this next extract, she also articulated traditional expectations of the protective and dominant role of a male partner.

*Sue, 32 years*

*"I was scared, but because he (partner) would do it for me it seemed OK. He told me it would block out all of my past, and I would feel that much better. So I thought he'd be right, because he knew such a lot about it, an expert. Now I've got more of a mind of my own. At that age, fifteen, I didn't have a clue."*

Many women (15: 26) claimed that they liked their partner to inject heroin for them and this gendered preference has been noted in other studies (Rosenbaum, 1981a; MacRae & Aalto, 2000; Powis *et al*, 1996), as well as the emblematic nature of this choice (Gossop, 1998). Bourgois and colleagues (1997) have

proposed that in doing so women symbolically reaffirm their subordination. On the other hand, a few (2: 26) women in North Cumbria justified their partner's role as a means of diverting some guilt about their drug injecting by handing over this responsibility. Furthermore, it has been argued that some women may use male jurisdiction over drug use as a means of controlling their consumption (Ettorre, 1992; MacRae and Aalto, 2000).

In some cases interviewees did inject independently and one interviewee insisted on doing this on the first occasion. It has been said that many women experience difficulty with veno-puncture since they tend to have smaller, deeper veins (Bellis *et al*, 2001; Hsu & Du Guerny, 1995), and this may also expose them to injection site injuries and infection. However, Brenda made the point that as a mother of five, she had regular experience of observing clinical tests and therefore felt more confident.

*Brenda, 28 years*

*"I didn't realise it was morning sickness because I thought I was rattling. I began to inject when I was pregnant, because smoking it made me feel sick. I wanted to do it myself, and I'd watched the doctors often enough. Felt for a pulse, popped a vein up and got it in myself."*

Many women (17: 30) went on to qualify these statements about curiosity and trust with explanations of influential personal circumstances. Nevertheless they retained the view that although these factors were influential, initiation into problem drug use had been their own decision. These factors further develop the argument of the complexities of women's initiation, and the following section will outline some of the examples provided.

### **Circumstances surrounding initiation**

A range of stressful circumstances was said to have preceded initiation into problem drug use and these could include: a partner's imprisonment; bereavement; depressive illness; or victimisation.

Another situation, mentioned by a few women (5: 30), was the influence of unplanned events when socialising with friends, and Michelle was deeply ashamed that alcohol intoxication had led to trying heroin. The recent British Crime Survey has revealed a consistent pattern of illicit drug use amongst regular drinkers who frequent pubs and clubs (Chivite-Matthews *et al*, 2005). It

has been said that in similar non-urban settings, opportunities for socialising can be more limited, often by the availability of public transport, and tend to focus on pubs and clubs (Henderson, 1998; Mentor UK, 2004). Now trying to abstain from drugs, Michelle also explained that it had become impossible to meet up with friends.

*Michelle, 25 years*

*"We (Michelle and husband) were out drinking with some of his friends and we'd had a bit too much really. Anyway we went back to their place and they got it all out and just the way I was I thought 'I'll have a go'. Just the drink - I'll always regret it."*

### **A partner's imprisonment**

Some women (5: 26) recalled that their partners' imprisonment sometimes led to the inception of intravenous use, because the source of supply was then dramatically diminished and heroin dependence forced greater economy of use. If women were unable to inject they sometimes (3: 26) reported having to *"pay back with heroin"* to another IDU to administer for them (Carlson, 2000), thereby increasing the need for financial resources, and often the pursuit of other criminal activities. The intensity and inter-dependence of some drug-using relationships has already been noted (Anglin *et al*, 1987), and Rosenbaum (1981a) has pointed out the increasing isolation from non-drug-using friends and family once heroin *'inundation'* takes place. This particular situation clearly had a profound impact on several of the women whose partners (14: 28) had served, or were serving custodial sentences. Interviewees declared that changes in circumstances and in particular a partner's incarceration, could promote the transition to injecting heroin and the progression of their addiction.

### **Grief and loss**

Bereavement and difficulties in resolving grief over the loss of a close relative or friend were frequently mentioned (10: 30) as an influence on interviewees' initiation. Young people living in disadvantaged circumstances are said to be more likely to experience serious and multiple losses, but it has been argued that the range of service provision is generally inadequate (Ribbens-McCarthy & Jessop, 2005). Sometimes death was accidental, but in this instance Linda's brother's death was drug-related. Linda had been estranged from her brother

before his sudden death and she described subsequent guilt, depression and increased heroin use.

*Linda, 23 years*

*"And then my brother died – it was solvent abuse. I was absolutely devastated, my family's never got over it, never ever. And from then on, well, people expected something like that to make us to not take drugs. But then my sister and my brother and all my mates we all ended up taking more."*

Some women (6: 30) had been brought up by grandparents, or had a very close relationship with them, and for them this loss seemed particularly poignant. Family dysfunction and disruption characterised many women's early years and one consequence appeared to be a central role for the extended family as informal carers. A recent study of young problem drug users has remarked that only 27% of the sample had grown up with both parents, whereas a national survey of 18-24 year olds reported that 70% were raised by their birth parents (Cawson *et al*, 2000). It has been asserted that living with both parents may inhibit drug use, but only if friendship networks do not facilitate access (McArdle *et al*, 2002), and it has been conceded that problem drug use is often mediated by other behavioural and conduct disorders (Miller, 1997). Ary and colleagues (1999) have identified that attachment, particularly to mothers, can be a significant inhibiting influence on drug use, but may itself be overwhelmed by the prevailing local drug-using culture and environment.

### **Depressive illness**

A few mothers (4: 18) proclaimed post-natal depression a precursor to initiation and other studies have remarked on this influence (Klee & Jackson, 1998; Taylor (1993). After a traumatic pregnancy, Kitty's frail baby caused a great deal of anxiety, and this young mother claimed that exhortations to socialise prompted her initiation into heroin, in an effort to improve her low mood.

*Kitty, 28 years*

*"And I got depressed after Sophie (baby), with all the worry about her spina bifida and dying and everything and him, he was all chirpy and that. And they said 'Get yourself out a bit more'. So I did and started knocking around with this lass. But I was that fed up and depressed, one day I just took some off her and well, I just felt a bit better. Know what I mean?"*

Finkelstein (1996) has observed the impact of low self-esteem, social isolation and depression on women who use drugs and that this may also increase their

vulnerability. Post natal depression (PND) affects up to 10% of new mothers and up to half of these will experience severe symptoms, but this treatable condition can still elude diagnosis (O'Hara *et al*, 1996). Important contributory factors are reported to be a personal or family history of depression, financial instability and lack of emotional or practical support, which may make some drug-using mothers particularly vulnerable (Farrell *et al*, 1998).

One young woman in this study identified the impact of confusion over her sexual orientation and she claimed that her family had found it impossible to access help with her adolescent depression and disruptive behaviour. She was adamant that low mood and self-esteem underscored her initiation into problem drug use. Recently, Huizink and colleagues (2006) have linked Ecstasy use by young adults who suffered depression and anxiety in childhood, suggesting that they may be more susceptible to its euphoric effects. Since the 1980s increasing numbers of young people have been diagnosed and treated for depressive illness, but Timimi (2004) has argued that it may be more appropriate to consider this 'childhood unhappiness', since symptoms differ and manifest more frequently as headaches, irritability and disaffection from school and family. She has maintained that the social context is often more significant than the individual, and has suggested the adoption of a multi-perspective approach based on non-medical interventions, which has now been incorporated into national guidelines (NICE, 2005a).

Copeland and Hall (1992) have pointed out the role of a partner's problem drug use as well as the impact of that on a woman's own psychological state. Depression and despair characterised Pauline's portrayal of her situation, and here she described long-standing efforts to help her husband towards abstinence. She made a particular appeal for service providers to consider the needs of drug users' families, believing that appropriate support could have prevented her own initiation.

*Pauline, 39 years*

*"Well, living with him (husband) as an addict for ten years can't have helped. But it was also the hopelessness of the situation. In amongst it all, and nothing ever getting any better. If you can't beat 'em, might as well join 'em, sort of thing. Everything I done, I couldn't beat it. I was just so emotional at the time, so stressed and depressed with it all. It was all of that, and I just give up, just give up."*

Pauline went on to describe the context of her initiation and described how she had coped with exclusion from her long-term addict husband's lifestyle, as well as his neglect of family responsibilities. She had developed a close relationship with her mother-in-law, since her own mother had abandoned her young family and she had no contact, but when Doris (mother-in-law) died, she said she resorted to drug use herself. Pauline declared that she did not blame her husband at all, though indicated that she would have looked to him for direction and support if he had been available, and she claimed responsibility for "giving in" to heroin use.

*Pauline, 39 years*

*"You see, I've been so used to sorting out my problems on my own all my life, I didn't know any other way. It's because of my past life and that, on my own, no-one ever there to advise me since we were married, I mean, he (husband) was always up by seven and out sorting himself out with heroin and I used to go up to his mother's with the kids, and then come back and get them sorted. He'd come home for his tea and then he'd be off again for his next lot. He wasn't around during the day at all, and I was working sometimes too, and I liked that. But when my mother-in-law died that all came to an end, I did the cleaning along with her when the kids were at school. It was all right but everything went out the window when she died. I tried to keep it going but I couldn't rely on Johnny (husband) to mind the kids if they weren't at school. I just gave in."*

### **Victimisation**

Domestic abuse, with resulting implications for health, has been deemed one of the principal factors in gendered health inequalities (WHO, 1997). It was reported to blight the lives of nearly half (13: 30) of the women in this study, and the impact of this gender-specific crime (Women's Aid, 2003) ranged from emotional cruelty to physical injury, and at least two cases of miscarriage. When that partner was a drug user, heroin was easily available and could offer some temporary respite from fear and misery (Zubretsky, 2002). Nevertheless, interviewees were still reluctant to contact helping agencies for fear of rejection, and Philip and colleagues (1997) have found that female drug users fear being judged harshly. The following extract reveals heroin's functional effect in this situation, as well as the self-blame that is commonplace amongst victims, or rather survivors, of domestic abuse (Dobash & Dobash, 1979; Hoff, 1990; Kirkwood, 1993; Mullender, 1996; Sargent, 1992; Stanko, 1985; Taylor, 1993).

*Brenda, 28 years*

*"But after Katy (daughter) I was using it to get by, to help me to cope, clean the house, tidy up and feed the kids. It was a different kind of using to speed and that. I mean, he (partner) used to give us a hiding if there was no tea ready when he came home. He used to hit us if he couldn't find his clothes. I was even beginning to think it was my own fault - that I deserved it in some way. And after the violence he said he was so sorry, so sorry and things were OK for a short while and then it started all over again."*

It is known that women drug-users frequently suffer domestic abuse (Fraser, 1997; Jacobs, 1998) but only a few UK studies have explored the links with substance misuse, either illegal drugs or alcohol (Finney, 2004; Flood-Page & Taylor, 2003; Gilchrist, 2003). Furthermore, poorer treatment outcomes have been observed for women with violent partners (Ravndal & Vaglum, 1994) and it has been suggested that there may be a complex recursive relationship between childhood abuse, substance misuse and domestic abuse (Jones *et al*, 2001; McKeganey *et al*, 2005). Campbell (2002) argues that some women may self-medicate to cope with the ensuing symptoms of post-traumatic stress, and are more likely to relapse if this trauma is not effectively addressed (Root, 1989; Swift *et al*, 1996), but few UK drug agencies report having appropriate skills (Jacobs & Tulloch, 1997).

This section has highlighted some of the factors chosen by interviewees as predisposing factors for their heroin use. A range of stressful circumstances and life events had mediated guilt and depression and several women linked this with their initiation. Acknowledging this influence, it has been argued that it is essential to carry out psychological assessment of female drug users in order to treat substance misuse more effectively (Blume, 1990; Boyd, 1993).

Concomitant with these factors, the presence of a drug-using partner was said to be significant, although apparently not coercive, and interviewees were insistent that initiation into problem drug use had been a personal choice. This finding is borne out by what the women said about the male reaction to their drug use and the following section will account for their comments.

### **Interviewees' accounts of male reaction to a partner's problem drug use**

The conventional impression of women drug users and their path into heroin use is that they have been encouraged or oppressed by men (Almog *et al*, 1993;

Anglin *et al*, 1987; Nurco *et al*, 1982; Reed, 1985). However, in this study the reaction to discovering a partner's heroin use was said to have varied from annoyance to indifference and disputes this theory. Linda, who had smoked heroin with her husband, was deeply upset by his response to her initiation into injecting and believed that his disapproval has had an enduring impact.

*Linda, 23 years*

*"He (husband) was in prison again. That time it was two years nine months for assault. I started to inject but oh, he was absolutely devastated because I'd injected and he'd never expected such a thing from me (voice lowers). I think he felt I was soiled and no better than anyone else on this estate. He wrote letters about it over and over again and told me off for it. It's took something from me."*

Many male drug users have been noted to retain traditional values in terms of disliking drug use in their partners (Klee *et al*, 1990; Rosenbaum, 1981a) and interviewees indicated that 'a double standard' often applied. Klee (1996) has proposed that drugs are usually injected to induce a quasi-orgasmic or euphoric state and that for some partners this is inappropriate and disturbing.

Interviewees gave various reasons for their partners' negative responses and these included the notion that his expertise and supervision would have been protective, as Michelle explained.

*Michelle, 25 years*

*"He (husband) was very, very angry with me. He didn't think it was a proper thing for me to be doing on my own. Different if he was there to look after me - but he wouldn't have me doing it on my own. He said it was because I was so gullible you see and I needed him to protect me."*

On the other hand some partners were said to have been simply resigned to her progression to problem drug use and appeared to accept the inevitable. Many women (16: 28) also asserted that men soon insisted or were content that they help with criminal fund-raising activities, including shoplifting and in a very few cases prostitution.

*Liz, 21 years*

*"He (partner) was taking at a time I never did. He was taking it all the time and going out housebreaking and that. And I thought, 'Well, if you can't beat them, join them' sort of thing. I said, 'I want to do like you', so he gave me some and said 'Right, you'll have to help with the shoplifting now'. And that was that then."*

Consonant with male perceptions, all of the women said they accepted responsibility for their decision to try heroin, and this has been noted in some other studies (Rosenbaum, 1981a; Taylor, 1993). They were very hesitant to blame their partners altogether and acknowledged that complex factors were at play, as Brenda explained.

*Brenda, 28 years*

*"Well, it would be easy to say it was Sean (former partner) and the pressure he put on me, but I also did it to feel comfortable and relaxed myself, but it was him that brought it into the house. I can't blame him entirely because at the end of the day I did it myself. I had the choice. All in all though if it hadn't been for him it wouldn't have been there and I wouldn't have been so desperate for a break. It's a lot of things tied up together."*

A further challenge to theories of male oppression is that in North Cumbria, a couple of women initiated men, previously heroin smokers, into using intravenously, and Elaine provided one such example in this extract.

*Elaine, 24 years*

*"But I feel guilty a bit because I think his (partner) heroin use has increased since we've been together. I've been a bad influence. To be honest I got him on to injecting. He was only smoking when I met him, and once we got together I showed him how."*

It was notable that a few (6: 30) respondents remarked that their heroin use was an assertion of their independence, and a reaction to gender restrictions which they perceived were placed on their group of female friends. Some commentators have pointed out that young people who misuse drugs are more likely to display personality traits such as rebellion, impulsiveness and sensation-seeking (Sarafino, 1990), rather than low self-esteem (Emler, 2001). In the following extract Cheryl indicates similar sentiments.

*Cheryl, 23 years*

*"It was just that other people were doing it at the time, and I wanted to see what it was about. Curious, I suppose. But also, I had just moved out of home into the Hostel. And for me, using heroin all seemed big and hard and clever. I needed to show people I was up to it. And also, you know, we needed to show the lads we were good as them, that we could handle the hard stuff. The gang of girls I was with."*

Several researchers have linked female drug use to notions of women's self-determination and sensual hedonism (Bourgois, 1995; Ettorre, 1992; Friedman & Alicea, 1995; Henderson, 1993; Measham, 2002; Parker *et al*, 1998; Taylor,

1993). In addition, many women succeed in developing acumen in '*drugs business*' and have been said to have particular skills in networking (Denton & O'Malley, 1999). Virtually all of the women in this study mentioned the pleasures of heroin, but it seemed that for some it could also provide '*social lubricant and social glue*' and a means of proactively defining the femininity of their own particular group (Hunt *et al*, 2002). Furthermore, Measham (2002) asserts that rather than emulating male substance use, drugs can provide a means of '*doing gender*'.

It was consistently asserted that overt male pressure to use heroin was not evident. Far from encouraging women's initiation, some partners apparently expressed disapproval and others resignation, although a few individuals were said to have taken the opportunity to develop an exploitative relationship.

### **Summary**

Interviewees advanced views on a range of influences upon their initiation into problem drug use, and although they did not form a homogeneous group, they identified consistent themes of early onset; curiosity; trust in those present at initiation; and predisposing life circumstances, explaining the complexities involved. They emphasised that these themes were underscored by key factors such as choice and personal agency, notions of emancipation and the desire for pleasure.

In Cumbria, early onset of drug use seems to present as a salient feature, particularly for some girls, and there is an ongoing need to provide young adolescents with the skills to resist substance misuse (McIntosh *et al*, 2005). Several interviewees had disengaged from school by the age of twelve and were often influenced by the example of other truants and older adolescents engaged in deviant behaviours, which has been noted to increase vulnerability to problem drug use (Hammersley *et al*, 2003). A recent analysis of links between smoking, drinking and illegal drug-trying among local young people has revealed a highly significant positive correlation (SHEU, 2005). A range of factors may be involved but early use may potentially intensify both physical and psychological dependence.

Like counterparts elsewhere, many women in North Cumbria linked their heroin dependence with the trust implicit in close, often sexual, relationships and an associated desire to share the experience of euphoria. The influence of such relationships as sites of risk management has been highlighted (Rhodes & Quirk, 1998) but may also present opportunities to deter initiation. One described her husband as "*an old-school user*" to whom it was unacceptable to initiate others in problem drug use and others described similar reticence. This sentiment may have the potential for revival and development amongst drug-using networks and sub-cultures. Hunt and colleagues (1998) have described a cost-effective intervention whereby drug workers offer current injectors strategies to avoid the initiation of novice users, prompting them to consider the impact of their behaviour. Since the majority of women began heroin use with drug-using partners this initiative might become an agent of prevention and change.

Although influential, relationships were not always supportive, and several women reported the incidence of domestic abuse, often in addition to childhood victimisation. There is now recognition of a life-course perspective on this cycle of abuse, and that early intervention, using a whole systems approach, may help to mitigate the effects on women's mental and physical health (Itzin, 2006). Adverse sequelae may include health risk behaviours such as: smoking; alcohol misuse; and problem drug use; risky sexual behaviour; and eating disorders, (Nurse, 2005).

Interviewees expressed confidence in their attitudes to the procurement of heroin and said they had "*known the dealers since we were all babbies*": this seemed to make it unthreatening and often part of social life (Henderson, 1998). Similar to other studies (Rosenbaum, 1981a; Taylor, 1993), active participation in '*drugs business*' was often described, but a couple of interviewees also developed sufficient expertise to introduce new partners to intravenous use, and were involved in the initiation of other women.

Within these similarities and differences, resonance with the theoretical frameworks both of initiation and female drug use, which were outlined at the beginning of this chapter, can be seen. The '*deviant careers*' of the women in this study began with individual curiosity taking them towards the '*invitational edge*', '*willing*' to sample intriguing substances. This initiation was virtually

always situated in a social context and the '*normalisation*' and '*habituation*' involved committed them to participate more fully. Once labelled as '*deviant*', relationships with family and other friends often became strained, reducing opportunities for non-drug-using relationships. For the majority of women the adolescent '*social world*' (Rosenbaum, 1981a) was characterised by dysfunction and victimisation, which they believed had made them susceptible to '*initiation*'. Women consistently explained that trust in a male partner could ease the crossing of '*the invitational edge*' towards addiction, although they contested any suggestions of coercion and claimed ownership of that decision.

On the other hand, the theoretical perspectives of Ettorre (1989; 1992; 2004), Henderson (1997; 1999) and Measham (2002) link women's drug use more positively to female empowerment and pleasurable experiences. Interviewees in North Cumbria declared that curiosity about heroin and the prospect of thrilling experiences was a factor in considering initiation and claimed that using heroin had relieved boredom.

In summary, interviewees recognised the influence of early onset of drug use, curiosity, trust, susceptibility and a range of stressful experiences in predisposing initiation into problem drug use, but they all took ownership of that decision to do so. Once initiated, interviewees said that the social context of heroin use encouraged them to engage more fully and '*inundation*' and dependence eventually ensued. Shared drug use with a male partner often typified the next stage of their '*career*', which could further affirm them as '*deviants*', and it was explained that increased risks were generated by the lifestyle and the nature of this intimate relationship. The next chapter will now describe the extent and context of these risks as well as the symbolism, structures and processes involved.

## **Chapter 3**

### **Sharing and Risk: Lifestyle, drug-injecting and sexual behaviour**

This chapter will consider the way in which risk characterised interviewees' drug-using lifestyles and underscored the pattern of sharing so frequently described in their narratives. It will begin by outlining the nature of these risks, as well as some of the factors influencing the shared activities surrounding heroin use. The women's accounts of their drug-using practices will be reviewed: the overwhelming majority (26: 30) was engaged in intravenous use.

The risks attached to the spread of blood-borne viral infections (BBV) among injecting drug users (IDU) are now well established and public health interventions offering sterile injection equipment to IDU are freely available in the UK. Despite this, there were accounts of sharing the use of potentially contaminated needles, syringes and other paraphernalia (such as filters, spoons or mixing water). Furthermore, interviewees said that decisions about sexual behaviour disregarded the likelihood of infection through intimate contact.

Instances of sharing seemed to be predisposed by the way in which a mutual interest in drug use served to bring people together, thus developing some kind of relationship. Interviewees explained that a shared heroin-using lifestyle often developed and could lead to joint criminal activities, which frequently jeopardised personal reputation and family contact. Cohabitation tended to increase the regular availability of drugs, and the associated rituals of drug consumption were said to promote equipment-sharing and dependence. It appeared from the narratives that this dependence could develop not only upon the substance but also upon the individual controlling its supply. Sharing a drug habit denotes a high degree of trust as well as an affirmation of identity, and many women referred to the additional protection against overdose or other mishap afforded by using drugs with a partner. These factors will now be accounted for and any opportunities to avert adverse health consequences will be reviewed.

### **Injecting drug-use and the risk of blood-borne infection**

In 1987, in response to evidence of epidemic spread of Human Immunodeficiency Virus (HIV) amongst IDU, the UK Government approved the free provision of sterile injecting equipment in dedicated needle-syringe exchange (NSE) facilities (ACMD, 1988; Gibson *et al*, 2001; Stimson, *et al*, 1988). The aim of this radical public health policy was to reduce the frequency with which IDU shared injecting equipment and thus the potential for BBV transmission, both to other IDU and to the wider community. Lack of awareness, combined with limited access to sterile supplies can provide optimum conditions for the spread of infection (Rhodes *et al*, 1999; Rhodes and Simic, 2005). Needle-syringe exchanges have helped to sustain the health of IDU, lower the long-term associated costs to society, and have reduced any ongoing risks of drug users transmitting acquired disease (Hurley *et al*, 1997; Trace *et al*, 2005).

As a result, the proportion of newly diagnosed HIV within IDU populations has reduced and remained low in the UK as a whole, and in North West England prevalence is reported to be 0.21% (Cook *et al*, 2003). A growing body of evidence has now confirmed that NSE have had a positive and cost-effective impact on the control of HIV infection amongst IDU (Cook *et al*, 2003; Des Jarlais *et al*, 1996; Gibson *et al*, 2001; Lurie & Drucker, 1997; Trace *et al*, 2005) and can prevent epidemic spread (Stimson, 1996). A recent World Health Organisation (WHO) review has concluded that NSE can substantially reduce the spread of HIV without any serious unintended consequences, but has warned that they are insufficient as stand-alone interventions (WHO, 2004). There is also some limited evidence to suggest that NSE programmes can be effective in discouraging novice users from continuing to inject (Hunt *et al*, 1998). However, McKeganey and colleagues (1995) have already cautioned against complacency since many IDU retain 'a preparedness to share', mainly with sexual partners and close friends, and they have indicated the fragility of prevention efforts when undermined by factors such as social obligation.

Furthermore, HIV infection may be spread through sexual relations, but here there is less evidence of behaviour change amongst IDU and inconsistency in the use of barrier protection appears to be the norm (Donoghoe, 1992; Donoghoe *et al*, 1989; Hartgers, 1989; Klee *et al*, 1990; McKeganey & Barnard, 1992; Morrison, 1991). It has been suggested that the use of condoms is inversely

related to emotional closeness (Friedman *et al*, 1992) and many IDU couples perceive such measures as irrelevant if they are already sharing injecting equipment (Klee *et al*, 1992). Moreover, since the introduction of treatments for HIV, Tun and colleagues (2003) claim that IDU have suffered '*risk reduction fatigue*', and have continued or returned to risky sexual practices. Cassell and colleagues (2006) have recently highlighted the need for renewed prioritisation and coordination of efforts to sustain awareness of sexual behaviour change.

In North Cumbria, HIV prevalence is low and at the end of 2003 there were fifty infected individuals known to be living in the area. However, in 2003 there were twelve new cases, two of whom were anonymously tested IDU, and this must be regarded as a worrying development (NCPCT, 2004).

Other blood-borne infections such as Hepatitis B (HBV) and particularly Hepatitis C (HCV) have greater infectivity than HIV and are an increasing public health concern. HCV was first identified in 1988, with a reliable blood test introduced three years later, but a vaccine is still not available. Disease progression and severity is very variable and patients may not become symptomatic until their liver disease, such as cirrhosis or cancer, is advanced. Vento and colleagues (2006) have pointed out that the main risk factor for disease progression to cirrhosis is alcohol consumption and that many IDU, the main population at risk, also drink alcohol regularly. In addition, Stein and colleagues (2002) have reported increased sharing of equipment by IDU who drink to excess, and recommend that alcohol misuse is addressed by services to help reduce the risk of infection.

Current estimates indicate that about 90% of people infected with HCV are current or former IDU (Jager *et al*, 2004; WHO, 2000). Injecting drug use is the most common transmission route in industrialized countries (Wodak & Crofts, 1996), but sexual intercourse carries a low risk for HCV (MacDonald *et al*, 1996; Blair & Hayes, 1997), as does breast-feeding infants (Yeung *et al*, 2001). It is fifteen times more likely than HIV to be transmitted through the percutaneous route and viral infection may remain in shared injecting paraphernalia, as well as in needles and syringes, several weeks later (Coutinho, 1998; Green *et al*, 2001; Hagan *et al*, 2001; Heimer *et al*, 1996; Zule, 1992). Furthermore, it has been found that many drug users do not recognise the risks attached to sharing

paraphernalia, such as spoon, filter and water, although sterile needle-syringes may be used (Bourgois *et al*, 1997; Carruthers, 2003; Green *et al*, 1997; Zule, 1992). Drug injection, as an invasive process, carries an enhanced risk of transmission, in addition to the sharing of equipment and this is often compounded by an unhygienic environment (Abdul-Quader *et al*, 1999; Carruthers, 2003; Hien, 2001; Kral *et al*, 1999; Spittal *et al*, 2002; Wood *et al*, 2003a; Wood *et al*, 2003b).

Despite well-established needle-syringe exchange schemes, HCV has continued to spread vigorously and a number of IDU persist in sharing equipment (Van Beek *et al*, 1998; Wodak & Crofts, 1996; Goldberg *et al*, 1998; Gruer *et al*, 1993; Taylor *et al*, 2000). It has been posited that current drug policy is failing to maintain established levels of protection against BBVs amongst this high-risk group (Judd *et al*, 2004). Indeed, Judd and colleagues (2004) have suggested that there may have been a significant increase in injecting drug use which has outstripped preventive educational interventions. It has been asserted that factors associated with HCV infection include: being female; having been imprisoned recently; or treated with methadone; aged over 25 years; having injected drugs for more than five years; and done so at least daily (Macdonald *et al*, 2000). Hunt and colleagues (2003; 2005) have argued that greater understanding of HCV prevention requires urgent attention and that there is scope to improve current service provision and practice.

Recent data confirm that nearly twenty years after the introduction of needle-exchange schemes, IDU are still vulnerable to a wide range of infectious diseases both by sharing practices as well as injecting site infections linked with poor hygiene (Beeching & Crowcroft, 2005). Women, and those with a longer injecting history, have been found to be most at risk of such wound-site infections, often inadvertently caused by difficulties in finding a vein (Bellis *et al*, 2001). It has been pointed out that women's veins are often smaller and deeper (Hsu & Du Guerny, 1995; Kral *et al*, 1999), and Epele (2002a) terms this '*a female anatomical peculiarity*'.

The Health Protection Agency has advised that in 2003, the prevalence of HCV doubled (18%) amongst novice injectors in the UK compared with 2000, and transmission of both Hepatitis A (HAV) and Hepatitis B (HBV) has continued

despite the availability of an effective vaccination programme (HPA, 2004). In addition, HIV was detected amongst this same population, whereas none had been identified in the earlier sample, and was now indicated to be at the highest level since 1990. Whilst acknowledging low prevalence amongst IDU, the Health Protection Agency asserts that challenging complacency must be a priority for renewed prevention efforts (HPA, 2004). Some commentators have proposed reasons for this high-risk behaviour, and point out the impact of situational factors such as limited access to facilities and ignorance of the harms involved (Barnard, 1993; Neale, 1998a). The discrimination and stigmatisation often experienced by IDU and women drug users in particular, have also been singled out as significant impediments to harm reduction (Habib & Adorjany, 2003; Crofts *et al*, 1997).

In North Cumbria, an audit of drug users treated in GP practices as part of the Shared Care Scheme, showed that only 16.9% had completed HBV vaccination programmes and less than half of IDU (41.8%) took up the offer of screening for blood-borne viruses (NCPCT, 2004). Amongst these, HCV prevalence was 28% and the proportion of IDU testing positive for exposure to HCV was 50%, double that of the previous year. As an additional concern, it has been shown that IDU not in contact with services demonstrate even higher levels of risk behaviour (Power *et al*, 1988; Stimson *et al*, 1988). Recent estimates suggest that NSE services supply IDU with one needle every two days, and it was noted that fewer than one in four IDU are in treatment at any one time (Hickman *et al*, 2004).

### **Explanations of risk behaviour**

Since it became evident that access to equipment was not in itself sufficient to prevent all instances of sharing, ethnographic investigations have sought to explain the social dynamics and the meanings inherent in this practice (McKeganey & Barnard, 1992; Power *et al*, 1996; Rhodes, 1995, 1997). It became clear that sharing equipment was not simply a deviant behaviour of this particular 'high-risk' group, but a product of social interaction (Bloor, 1995; Friedman *et al*, 1990; McKeganey & Barnard, 1992). It is particularly common between sexual partners or close friends (Barnard, 1993; Dear, 1995) and women have been shown to be more likely to be recipients of used syringes than their male counterparts (Dwyer, 1994; Bennett *et al*, 2000a; MacDonald *et al*, 2000). McKeganey and Barnard (1992) have identified six influential factors, not

mutually exclusive, which were: accidental or inadvertent sharing; limited availability; a need to inject; individual assessment of risk; social norms; and the nature of the relationship involved. They commented on the normalization of sharing within drug-using sub-cultures, as well as the cultural rights and obligations which temper the meaning of sharing or the salience of risk within a social situation.

Several studies have indicated that pragmatic reasons such as the scarcity of sterile equipment increase the likelihood of multiple usage (Barnard, 1993; Connors, 1992a; Crisp *et al*, 1997; Macrae & Aalto, 2000). It has been said that sharing equipment can represent bonding or defiance, with the rituals involved defining a sense of belonging to a group (Des Jarlais *et al*, 1986; Gossop, 1998) but Carlson contests this view (1996) arguing that this is '*victim blaming*'. Furthermore, Bourgois and colleagues (1997) claim that drug users may often share any available equipment and paraphernalia because of the urgency attached to withdrawal.

Novice users may be particularly vulnerable in the early stages of their career when less aware of risks, and women often depend upon a male partner to administer heroin, in a situation of unequal power (Klee, 1997). Addicts' sexual relationships have been ascribed '*sites of risk management*' by Rhodes and Quirk (1998), who contend that drug use may compromise the stability of a relationship, and that IDU must also negotiate this along with the likelihood of specific health-related harms. Rhodes (1997) has also commented that a lifestyle of daily heroin use is permeated with risk and health-related risks may not be the major concern. Nevertheless, Des Jarlais and colleagues (1994; 1995) have proposed that IDU can be helped to reduce their risk behaviour if they are provided with meaningful and timely information and resources.

Some commentators have pointed out risks attached to using illegal drugs can be greater for women addicts and the next section will outline these reports of risk behaviours. It has been said that women soon become '*inundated*' within drug-using networks (Rosenbaum, 1981a), and it seems that their relatively greater risk of infection is determined more by the behaviour of those with whom they interact: their friends and sexual partners (Montgomery *et al*, 2002).

### **Gender differences in risk behaviour**

Whilst all drug users are at potential risk of BBV infection, it has been asserted that women drug users may double their risk of HIV from a propensity to share equipment with male drug-using sexual partners (Donoghoe *et al*, 1989; Robertson & Skidmore, 1989). It has been established that women who are more severely dependent upon heroin are more likely to have an IDU partner and to be in a current relationship with one (Barnard, 1993; Bennett *et al*, 2000a; Donoghoe *et al*, 1989; Gossop *et al*, 1993; Griffin & Mirin, 1989; Hser *et al* 1987; Klee, 1993; White *et al*, 1993). One implication is that male IDU who are in liaisons with non-using partners may then be better able to control their drug use, and Klee (1992) has suggested that this restraining influence may therefore not be available to female IDU.

Frequent injecting can promote immuno-suppression and increased susceptibility to infection (Mientjes *et al* 1991) and women have been shown to be more biologically vulnerable to sexually transmitted HIV infection (Nicolosi, 1990; Stoneburner *et al*, 1990). Furthermore, gender differences in rates of response to highly active anti-retroviral therapy (HAART) have been demonstrated (Kuyper *et al*, 2004). This variation was attributed to a disproportionate prevalence of female IDU among the study population, among whom it was said psycho-social factors influenced incomplete adherence. A French study which examined BBV risk behaviour amongst a group of IDU claimed that women were more likely to report inconsistent sterile equipment and condom use, along with low educational attainment, single motherhood and unemployment. On the other hand, their male peers displayed multiple indicators of sexual risk behaviour and could therefore be more receptive to a range of harm-reduction interventions (Vidal-Trean *et al*, 1998).

The majority of drug users will be injected by another IDU at initiation (Crofts *et al*, 1996; Roy *et al*, 2002; Vidal-Trean *et al*, 2002) but many women continue to be dependent on another for this service, usually a male partner (Eicher *et al*, 2000; Evans *et al*, 2003; Kral *et al*, 1999). Some researchers suggest that in doing so these women may be trying to protect themselves from injection site injury because men are usually more experienced and proficient, or even to control their injecting drug use or its frequency (Macrae & Aalto, 2000). In addition, women drug users are often dependent upon their partners for access

to drugs (Powis *et al*, 1996) or for procuring sterile equipment, in order to hide their heroin addiction from public scrutiny (Barnard, 1993). This reticence to reveal their drug dependence often affects women drug users' access to other treatment facilities, and it has been claimed that this can be influenced by professed anxiety over loss of custody of any children (Lewis *et al*, 1995; Lex, 1991; Rosenbaum & Murphy, 1990; Taylor, 1993).

HCV has rarely been identified as sexually transmitted (MacDonald *et al*, 1996) and therefore the demonstrable differences in incidence rates between male and female novice injectors seem to be non-biological in nature (Garfein *et al*, 1996). It has been argued that some male IDU may even avoid relationships with current female IDU because of women's perceived susceptibility to BBV infection (Van Etten & Anthony, 1999). The significance of sexual relationships in the spread of blood-borne infections among IDU has been extensively documented (Padian *et al*, 1993; McKeganey & Barnard, 1992; Montgomery *et al*, 2002; Neaigus *et al*, 1995; Price *et al*, 1995; Rhodes & Quirk, 1998).

Furthermore, Miller and Neaigus (2001) argue that the overlap between women's social networks, including their sexual partners, and risk behaviours may be higher than that for men. They conclude that the bonding induced by this close-knit subculture may influence women's sharing and other high-risk activities, increasing their exposure to infection. Once initiated, women's social circles appear to concentrate on drug-using associates and they mix less frequently with non-drug users (Fullilove & Fullilove, 1989; Price *et al*, 1995). Conversely, Latkin and colleagues (1998) and Valente (1995) argue that these networks may also present an opportunity to influence a self-selected group's norms by diffusing appropriate harm reduction interventions.

This overview has outlined the scale and impact of the risks inherent in the drug-using practices which interviewees said they soon adopted as part of the heroin lifestyle. The meaning of these choices will next be considered, with a reflection on women's views of the prevailing influences. In their narratives, the women explained how their shared drug-using lifestyle could offer either: solidarity or increased isolation; criminal activity and violence; or personal safety. Some interviewees professed naïvety of the risks involved therein.

The following two sections of this chapter will examine the risks attached to sharing the drug-using lifestyle, as well as the risks to the women's health and well-being from drug-related infections.

### **Sharing the Risks of a Drug-using lifestyle**

Rosenbaum (1981a) has described the ways in which heroin use may provide instant gratification in terms of the 'high' of euphoria following consumption, as well as offering the 'life', which could infuse excitement, meaningful activity and purpose into a dull existence. She argued that this 'life' might become particularly tempting to those who have 'a minor stake in society's material rewards'. Interviewees in North Cumbria recalled becoming drawn into Rosenbaum's (1981a) 'addicted world' through their social networks, often with a male partner. The transition to injecting drug use seemed to be regarded as symbolic of a qualitatively different level of addiction, but several interviewees (8: 30) expressed a mistaken belief that smoking heroin would avoid dependence. Contemporary research has noted the importance of social factors that influence drug users' risk-taking behaviour (Bloor *et al*, 1993; Connors, 1992a; Kane, 1991; McKeganey & Barnard, 1992; Rhodes, 1997) and this resonates with the findings of this study. It was consistently reported (30: 30) that heroin use was a shared activity which served to draw people together, and Fiona's extract illustrated this.

*Fiona, 24 years*

*"My boy-friend used to come into town for it. There wasn't much about in the village where we lived. We both got properly into it together, because we were round at somebody's house, and we both tried some there, and it kicked off from there. At first it was mainly weekends, something to chill out on after dancing and that, and then he came in to quite a bit of money, got left off a relative, so we spent it all on heroin."*

Experiencing the 'high' together was frequently portrayed as a pleasurable shared activity and in the next extract, Moira explained the significance of this commonality and mutual interest which had become central to her marriage. She also described the move to intravenous use as a more risky development which deepened her 'inundation' into problem drug use (Rosenbaum, 1981a).

*Moir, 40 years*

*"I started smoking with them (husband and his friends) and then eventually went on to injecting. That felt like it was getting serious then, I knew it would bring trouble, but the thing was I'd got to like it. Yes, and we shared everything between us. It became something we enjoyed together, it drew us together again. I got sucked in and nothing seemed to matter any more."*

This experience of shared activity and relaxation was portrayed by most of those women (22: 28) who had ever been in an addict relationship and Rhodes and Quirk (1998) have argued the significance of this 'site of risk management'.

Heroin use appears to have an effect upon, and be influenced by the intimacy of a sexual partnership and this will be further analysed in a later chapter.

On the other hand, Sally expressed ambivalence about heroin's sedative effects: in her experience, oblivion was not always welcome. Women are often socialized into a conventionally nurturant role where sensual hedonism meets disapproval (Ettorre, 1992; Klee, 1996), in addition to any concerns they may have about personal safety.

*Sally, 40 years*

*"I did like it at first, and then I didn't. I liked the initial hit, when you feel nicely calm, but what I didn't like was waking up five hours later and you don't know what might have happened to you. I didn't like the idea of losing control."*

Rosenbaum (1981a: 47) has noted that heroin's euphoric effects are both physiological and psychological and can relieve the tension produced by interpersonal interaction, 'the smoothing out of an otherwise rough world and the elimination of all problems and worries'. Interviewees portrayed the initial sense of general well-being resulting from heroin use and often attributed to it a feeling of "being more alive". Several women (13: 30) claimed that they used the 'high' from heroin to cope with difficult relationships and circumstances, and Ettorre (1989, 1992) has remarked that women often use a substance to relieve oppression and victimization in their lives. The following extract indicates both the functional effects of heroin, in relieving social pressures but paradoxically in increasing the women's dependence.

*Liz, 21 years*

*"It was probably the heroin that held me back. I was just wrapped up in my own wee world. But I often think the heroin began at the same time as the violence, and that it wasn't a coincidence. It helped me shut some of it out, and in that way it worked. But it also locked me in there."*

Both Rosenbaum (1981a) and Taylor (1993) have commented on the excitement and activity of the shared heroin-using world and the attractions of the 'life' therein. Many aspects of this developing drug-use or 'apprenticeship' stage (Rosenbaum, 1981a) and concomitant criminal 'career' initially seemed to relieve the boredom of a mundane existence. Indeed, Rosenbaum (1981a) argues that a key and constant aspect of the heroin world is 'riskiness' and the thrill of 'getting away' with illegal pursuits. Integral to this 'riskiness' is the need to separate from non-users and to form safer social networks with other addicts, to avoid public exposure and possible arrest. However, women took care to point out that these networks were "associates" and not "true friends" who could be trusted, and Jade was one who offered cautionary advice, highlighting the absence of real 'camaraderie' (Rosenbaum, 1981a).

*Jade, 18 years*

*"And if you're a drug user, you can't trust nobody. If you're a user and desperate you'll pinch off anybody, no matter who it is. And if you're betrayed it's finished. You must never, ever trust an addict."*

### **The risks to reputation and close relationships**

The increasing isolation from family and friends was frequently remarked upon by interviewees (21: 30), and they expressed guilt about the acute anxiety and distress caused by their pursuit of a 'deviant career'. Loss of reputation was a recurrent theme, with its impact on future relationships and employment prospects. In this extract Elaine explained how she risked her job and her relationship with family because of her addiction to heroin.

*Elaine, 24 years*

*"I went to college and did a catering course, and after that I decided to go to the Channel Islands, and I got a really good job out there, earned a lot of money over the summer. I was a good worker, and I really enjoyed the job. But after the summer I came back here to another good job and met Alex (addict boyfriend) and got into heroin but with that it was hopeless. I couldn't cope and all my savings went on buying it - I got the sack. Mum and Dad wouldn't have anything to do with me, none of the family - it was just a nightmare."*

More than half of the women were themselves mothers (18: 30) and all of them mentioned that the risk of losing custody of their children was a great source of anxiety and an unwanted consequence of sharing the drug-using lifestyle. Some observers have warned that losing custody of children can prompt further drug-

taking and integration into the 'life' (Griffiths & Pearson, 1988; Matthews, 1990), although the safety of children must always be paramount. Conversely, for other women, this traumatic experience was pronounced the necessary incentive to attempt abstinence (Rosenbaum, 1997; Taylor, 1993). In the following extract, Jackie was one who was able to articulate the importance of knowing that her second baby would not also be taken into local authority care for adoption, and she explained that this had provided the impetus to persevere with treatment.

*Jackie, 22 years*

*"I asked Social Services and they said they wouldn't take him (baby) off us this time if I was trying to come off and I had a good relationship. That first partner was very violent, and that was part of it before. But if I was making the effort to come off, and they could see I was trying, they wouldn't take him off us. And I was over the moon. I decided I was going to keep my babby and come off the heroin. And I've done it - I've been off for nearly four months now. I've just got to look at my little lad, and he's gorgeous, and I'd never let myself get into that mess again. That's what made the difference."*

Children were regularly portrayed by interviewees as motivators for change in their mothers' lives, and in Chapter 5 their comments on this influence will be reviewed in more depth. Many mothers (12: 18) acknowledged their inability to supervise children when intoxicated with heroin, and the potential risks from a range of accidents and misadventures, not least drug-related ones. Nearly half of these women (8: 18) reconciled this by explaining that grandparents could assume parental caring responsibilities, and many children seemed to spend a lot of time in the care of family support networks. It seemed that many grandparents (14: 18) had been asked to find the personal, emotional and financial resources to support their extended families in some way for varying periods of time, such as immediate child-minding, outings, treats and necessities. In the next extract, Alison explained that her mother had become a long-term foster carer for her three children, but her mother's views on this commitment remain unknown.

*Alison, 36 years*

*"I mean, I took my kids to my mam voluntarily. My mam got custody and Social Services said I shouldn't see them, so my mam stood up to them and said, 'Alison's many things, but she loves her kids'. The youngest one is still living with her, he's 11 now."*

### **The risks of involvement in criminal activities**

It followed that full engagement in the 'life' meant there was rapid absorption into *inundation* when, according to Rosenbaum (1981a), all of an individual's concerns and interests pivot around an addict identity. It has previously been noted that women drug users tend to form relationships with male counterparts and this was also a consistent theme for interviewees (Davies *et al*, 1996; Gossop *et al*, 1994; McKeganey & Barnard, 1992). Jo went on to explain that once addicted, options in her personal life had suddenly become limited, since all the members of her social circle were addicts. Jo had separated from her long-term partner when her heroin use was disclosed, and she explained in the next extract why it would now be difficult for her to establish another relationship.

*Jo, 30 years*

*"Well, you either meet someone who's on it themselves, and then you've doubled your battle, two of you trying to get free. And if he wasn't, once he found out, he wouldn't want to know you and that's more heartbreak for everyone. There's not many people that I'm mixing with, or was, that aren't on it"*

This intense shared focus of interest could provide necessary commonality within a relationship, and the teamwork required to finance, obtain and consume heroin established the bond. One consequence of cohabiting with an addict, particularly if he was also a drug dealer, was said to be an escalation of heroin consumption and further 'inundation'. Gemma was increasingly aware of the consequences of sharing her drug-dealer husband's criminal lifestyle, and was now fearful of being involved as a witness in his forthcoming trial for possession of a large quantity of heroin, with intent to sell.

*Gemma, 27 years*

*"He (husband) used to buy it in bulk, £700-worth at a time, down at a city dealer, and divide it all up. It was cheaper that way, he said. He always used a lot more than me, and he always seemed to have plenty of money. Now I know that was all the crimes. He's up in Crown Court soon".*

Heroin dependency requires the regular purchase of supplies, often funded by criminal activity, and Pearson (1987) argues that this 'dismal compulsion' structures the life of addicts. Rosenbaum (1981a) and Taylor (1993) have also remarked that crime is a concomitant part of the lifestyle, but have noted some of the positive aspects of having a daily routine, and that many of their interviewees gained status from these illegal achievements.

Many (21: 30) interviewees in North Cumbria admitted involvement in theft, shoplifting or drug dealing to support both their own and often their partner's heroin expenditure, sometimes of several hundred pounds a week. None of the women claimed to have enjoyed this criminal aspect of the heroin lifestyle. Many women (16: 21) said that once they had become dependent on heroin male partners had encouraged them into criminal activities which became a shared venture, and the following extract was a typical response.

*Pauline, 39 years*

*"Shoplifting. He (husband) was an expert. But when I got into it, he seemed quite happy after a bit, that he could get me to help with the thieving too. I didn't like it, but it just had to be done to get the money. There was no other way. In a way, that became something we actually planned and did together. But I seemed to get caught more and now I'm on a DTTO."*

Some men (6: 21) were said to consider certain crimes, such as burglaries and house-breaking, unsuitable for their partners, and interviewees seemed to accept this as a form of protection and risk-reduction. This gendered division of labour of addiction and associated activities has been noted in other studies (Barnard, 1992; Powis *et al*, 1996; Steffensmeier & Streifel, 1993). In the next extract, Kath portrayed the pressures of the recurrent cycle of securing the means to buy and use heroin, and indicated this addict couple's utter weariness with it all.

*Kath, 28 years*

*"We were spending hundreds a week. Paul (partner) was into burgling and we were selling drugs too. I didn't like selling. Some of the people were scary. He didn't allow us to come burgling, though; he said he wanted to protect me from all that. I've got a record for shoplifting, though. We got tired of it together, all the pressure of it all, and decided to pack it in. Getting the money, getting the gear, it's endless."*

A few women (8: 30) spoke about the male exploitation of their homes by partners using them to set up a base for drug dealing. Cindy explained that her young age and status on the housing priority list meant that accommodation was quickly made available, and that this soon became a venue for selling heroin: some of the single mothers (3: 8) recounted a similar story.

*Cindy, 17 years*

*"Well, I was just started taking it and then I got a boyfriend, and he had a brother who was into it and we all got together. So it was easier with three of us and we could get quite a lot with thieving and whatever. It was a bit easier for me because I wasn't known to the shops and that. And then we managed to get a flat when I was sixteen and then we could get into dealing and that made a very big*

*difference – it was a lot of money, a lot of money that way. Getting the flat was the main thing up on the estate, once I got that and he moved in we could deal from there. He knew all about how to organise it all – I just did what he said really.”*

Another interviewee described her boyfriend's manipulative power in using her house as a refuge after major robberies. Sally described a lifestyle of constant disruption and criminal chaos, as well as the additional risks attached to the handling of stolen goods. Her partner had been imprisoned and although she had escaped arrest, she was now fully aware of the risks she had taken.

*Sally, 40 years*

*“He (partner) was doing a lot of crime at the time and needed me to be awake all the time so that they could come back to my house in the early hours of the morning. I just needed to be the bolthole. It was the way they did it, organized the crime. Do it, split up, and then everyone meet up back at my house. And that became his house as well. And that could be any time of the day or night, people coming to the house all the time at all hours. It brought me a lot of trouble. He got jailed eventually, breaking into pubs, raiding cigarette machines, ram-raiding stores, videos, TVs, all sorts, loading a van and then driving off. I didn't do that, but had all the stolen property in my house, loads of it. It was really dangerous, big money at stake.”*

Prostitution has frequently been attributed as a commonplace means of funding an addiction for women drug users (Rosenbaum, 1981a; Freund *et al*, 1989; Taylor, 1993; McKeganey & Barnard, 1996; Inciardi & Pottieger, 1998), but only a couple of interviewees admitted any involvement. Macrae & Aalto (2000) have commented that prostitution was generally unavailable to their interviewees in Dundee, unlike their counterparts in the larger cities of Glasgow and Edinburgh (McKeganey & Barnard, 1996; Morgan-Thomas *et al*, 1989, Taylor, 1993). Both of the women who did say that this was their principal means of financing their drug habit were aware that they had taken many personal risks. They both pointed out resentfully that partners had influenced continued prostitution and had benefited from the proceeds.

*Sue, 32 years*

*“I spent a fortune with him (partner), my money. I could be a millionaire by now. He (partner) just used me to earn money for both our habits. Once he saw I could earn it, he sent me back on the streets and kept me working and kept me wanting it. I got really, really sick of it.”*

### **The risks to personal safety**

On the other hand, some women (10: 28) put forward more positive notions of reliance on a male partner for personal protection against both overdose and attack by other addicts. Cindy explained that this was an important justification for shared drug use and engagement in the lifestyle, and depicted scenarios where she had felt less vulnerable to be in the company of her partner.

*Cindy, 17 years*

*"Very, very scary, we went to some very dodgy places, men with guns, I was terrified really. I was alright because he (partner) was there but I was nervous about it. I was lucky there really because I know girls who have got beaten up. There's a lot of money at stake and people get desperate. But even though they all went to hospital nobody grassed up to the police. That's a thing with drug users too."*

A couple of women who were not currently using heroin with a boyfriend further illustrated this by identifying 'scoring' or procuring heroin as potentially a tense and anxious experience, when they could fear assault from dealers or other addicts. Jo suggested that this could be different for women with addict partners, especially if heroin was scarce and it had to be acquired from unfamiliar dealers in unknown areas.

*Jo, 30 years*

*"Well, you'd be running around everywhere, in and out of phone boxes, and you ring and arrange something and say you'll phone just before they bring it. And you have to stand there and wait for someone to come and meet you. And sometimes you didn't know the person. It might be dark, and you're not 100% sure of the person. It's probably different if you're using with your partner, because girls who have a man often get him to fetch it. I used to avoid going on my own, and I'd fetch somebody else with us. But, to be fair, a lot of the time it's people who you know who you get it from, grown up with them. But times when it was a bit scarce, it was different."*

Despite this fear and anxiety, a kind of moral code amongst drug users was often said to prevent serious injuries being reported to the Police or other agencies. Interviewees frequently remarked that if they obtained supplies independently, it was generally from individuals known to them from childhood, and it has been argued that this may be a feature of similar settings (Henderson, 1998). In general, the threat and fear of violence appeared to be commonplace and something that many women said that they came to accept. Cindy was one who

remembered, with some trepidation, witnessing an incident when her boyfriend was violently attacked by other drug dealers.

*Cindy, 17 years*

*"It was terrifying. They were knocking at the door and Ricky (partner) had the key so I couldn't open it and they kicked the door in. Three of them and stabbed him (partner) five times. There was blood absolutely everywhere. Then his brother came and hit this guy with a spade – half his face was hanging off. It was all to do with the dealing."*

Drugs overdose was universally dreaded and many reflected with sadness on the deaths of various drug users who were known to them, including siblings, cousins or partners. Witnessing overdose was clearly distressing and many women had been revived, or had been involved in resuscitating other drug users. Despite this fear, the women were prepared to continue their drug use but said that by collaborating with an experienced male partner they felt they were reducing potential harm. Neale (2002) has asserted that risky behaviour, such as drugs overdose, is often perceived by addicts as either an inevitable hazard, or as a reaction to overwhelming problems and circumstances of daily life. In the UK in 1997, it was reported that drug-related deaths caused a similar number of years of life lost as road traffic accidents, and accounted for 5% of all male years of life lost (ACMD, 2000). It was a risk that all interviewees mentioned and in this extract, Jan recalled and described such an incident, thus justifying her preference for shared heroin use with a partner on the grounds of risk reduction.

*Jan, 30 years*

*"Once I overdosed mind, in the bedroom and I didn't know anything about it happening. I'd have died likely if he (partner) hadn't of been there. I remember injecting meself and it was quick. Anyway, he'd (partner) just had his hit and he heard a thump and that was me on the floor with a needle stuck in my arm. He was dead worried – thought it would have to be an ambulance and everything, he said he was hitting us on the chest. I realised I was safer doing it with him because he could look after me if it went wrong somehow. It felt more safer to be using together as well as something we shared together. A bit of help."*

Nevertheless, fearful as they said they were, those interviewees who had suffered or been present at an overdose incident did not imply that in itself it was a significant deterrent to further injecting drug use, but more of *'an unavoidable risk of drug-taking and in practice beyond personal control'* (Neale, 2002: 179). Jackie provided a detailed description of one terrifying experience of overdose

which revealed her fear, as well as her own incredulity at her rapid return to injecting heroin.

*Jackie, 22 years*

*"Just taking it was dangerous. Overdose. I died once and if it wasn't for Jim (partner) I wouldn't be here now. I didn't even remember a thing. That's the thing with overdose: you don't know until it's too late. I couldn't stop shaking when he brought me round. I'd gone completely blue, and I'd stopped breathing. He'd done First Aid and knew what to do. But, you know, even though that was really terrifying, I couldn't stop taking it. Everyone tried to persuade me to stop then, but I went back on right away. Heroin was still in my head, and basically I didn't want to come off it enough."*

### **Summary**

In summary, this section has reviewed interviewees' accounts of a spectrum of risks involved in sharing drug use with a sexual partner, often within a drug-using social circle, and of becoming integrated into the heroin lifestyle.

Using an illicit substance with a partner was inherently imbued with risk and sometimes thrill, but interviewees soon became aware of the potential threat to: reputation; personal safety; childcare; job; family bonds or friendship networks once they became involved in addiction. Many of the women had become involved in crime, but becoming '*labelled*' as an addict was sufficient to pose a risk to their previous lifestyle. Interviewees said that this was now deeply regretted but explained that once they had become absorbed into an addict *persona*, their priorities seemed to have changed.

The powerful influence of the social context in which heroin was consumed, as well as its dependence-inducing properties ensured that once initiated, there was a rapid progression to '*inundation*'. This '*apprenticeship*' stage of the '*career*' (Rosenbaum, 1981a) drew the women into daily routines which focussed solely on acquiring the means to secure and use heroin. It was reported that isolation from non-drug-users further enmeshed women in the '*life of narrowed options*' (Rosenbaum, 1981a) and recidivism. Faced with the limitations of poor educational attainment, many interviewees had found it impossible to aspire to any career, and Taylor (1993) has argued that her interviewees in Glasgow had suffered these '*narrowed options*' (Rosenbaum, 1981a) from the beginning. The shared drug-using lifestyle with an addict could offer excitement, mutual

interests and skills development, but the custom and practice of joint drug preparation and use could also predispose to serious infection and illness. These risks to health and well-being will now be discussed in the next section.

### **Sharing the Risks of Infection**

As previously outlined, the lifestyle surrounding injecting drug use is 'a *risky business*' (Rosenbaum, 1981a: 49). However, there are some specific instances where IDU are placed at serious risk of health-related harm, through the sharing of injecting equipment and paraphernalia, as well as unprotected sexual relations. The risks of blood-borne viral infection have already been noted and, IDU may be susceptible to septicaemia, bacterial infections, deep vein thromboses, endocarditis and rheumatological problems. Interviewees revealed that seropositivity was rarely discussed with, or disclosed by partners, and since less than half of drug users attending treatment in North Cumbria had accepted testing for BBV, many were unaware of their sero-status (NCPCT, 2004). Only a minority of interviewees (4: 26) claimed never to have placed themselves at risk through exposure to contaminated equipment, although closer investigation of definitions of "*sharing*" sometimes belied this assertion. The following sections will describe women's accounts of drug-using and sexual behaviour which had the potential to increase their risk of infection and illness, and will consider any influential factors which they mentioned.

### **Influences on sharing drug-injecting equipment**

It has been asserted that sharing injecting equipment happens most frequently between those with whom there is an existing or established emotional or social bond (Calsyn *et al*, 1991; McKeganey & Barnard 1992). McKeganey and Barnard (1992) identified a number of influences on the sharing of injecting equipment in their study in Glasgow and these included: individual assessment of risk; the need to inject; availability of sterile equipment; the pressure of social norms; and the nature of the relationship involved. Similar factors were revealed by interviewees, but a number of them claimed never to have considered health-related risk relevant until someone known to them had become infected. In fact, many women (18: 30) pointed out that the most salient risk for drug users was the threat of overdose and that the chance of infection therefore assumed a lower

priority. This may suggest that health protection campaigns about the risks to drug users from BBV infections were insufficient to motivate behaviour change, and may indicate that more potent influences prevailed. Here, Jackie explained her perspective on risk behaviour.

*Jackie, 22 years*

*"A lad I know just died yesterday. He'd just got clean, and then met up with an old mate, so he overdosed and that was it. That's the trouble with overdose - you just don't know you've gone over until it's too late. That's the thing drug users worry about more than health things like hepatitis and that. Well, I know a few people that have it, but luckily I'm clear. I don't think people really think that much about it. Only if it affects somebody you know. People just assume, if they look all right, they can't have anything. And if you need a hit then you'll want it there and then. Health things like that aren't always the biggest worry somehow - it's just a chance you have to take."*

Amongst those women who used heroin intravenously, a few (4: 26) claimed that they had never shared injecting equipment or paraphernalia, but others (10: 26) even expressed fatalism and consigned the risk of serious infection to being integral to heroin use (Neale, 2002). Frequently, there was ambiguity expressed in relation to definitions of exclusive sharing, and Liz provided one such example when she admitted sharing equipment with her boyfriend. She also indicated that the risk of infection was of little relevance in her relationship.

*Liz, 21 years*

*"I shared with him (partner), only him, though. And Claire (close friend) sometimes, but mainly with him. I just felt, if he's got something, I'll have got it too by now, like it couldn't really matter, I would just put up with it."*

Consistent with previously noted studies, the women's drug use took place in a social setting and was influenced by group interaction and prevailing norms. The obligation to "help out" another drug-user who might be suffering withdrawal or might need injecting equipment was often declared (13: 26). Peers could share understanding of the urgency to inject when heroin became available and solidarity appeared to permit, and even approve, shared use of equipment. Several studies have confirmed that the more dependent an individual becomes, and the more demanding the urgency, the more likely they are to share needle-syringes (Bennett *et al*, 2000b; Bourgois *et al*, 1997; Gossop *et al*, 1993; Hunter *et al*, 2000; Klee & Morris, 1995; Steffen *et al*, 2001). Jade was working as a prostitute and explained that for her the risks of blood-borne infection competed with those of sexual or physical assault, arrest, robbery or even murder (Epele, 2002b; Weeks *et al*, 1998). She explained her attitude to risk in this extract.

*Jade, 18 years*

*"I've done it quite a lot, actually (sharing injecting equipment). I've had the tests now and they've all come back negative. It's really very scary to think about it, the risks we all took. There were a few of us, and we all used together in someone's house. Sometimes it wasn't easy to get needles. If there's only one needle, and you've got the heroin, you think f\*\*\* it, just go and do it, kind of thing. Your life is so full of risks as a drug user, it's just one of many. You could get the needles all right, but I'm banned out of most of the chemists, and so were my mates."*

It became clear from interviewees' accounts that health-related risk was something rarely discussed between those who were involved in injecting drug use together. However, there was evidence of some kind of risk assessment of those individuals with whom it seemed "safe" to share equipment. In the following example, Jan illustrates the intuitive nature of the criteria which determined who might be a carrier of infection.

*Jan, 30 years*

*"We never talked about it because well, Tom (partner) had never shared and he would never let anybody, you know. If somebody come till him, like one of them scumbags, he'd lend them but not borrow off them, if you know what I mean. Never have them back – he was particular too. There's clean users and the dirty ones who don't care if they squirt blood all over the floor and stuff. Just by looking at them, you'd know them apart you can just tell if they would share needles and that. You can just tell."*

Nevertheless many (16: 26) of the women said they did make efforts to minimise harm, and Sharon said this also included the decision to lend needle-syringes, but refuse their potentially contaminated return. The following extract indicates the influence of knowing IDU who have contracted infection, as well as sentiments of a moral code which could inhibit the onward transmission of disease. Crisp and colleagues (1997) found that those IDU who claimed that they were infection-free were viewed with scepticism by their peers.

*Sharon, 22 years*

*"I know quite a few with hepatitis, loads in fact, now. I mean, people will say, lend us yours, and I won't let them have mine. I don't even pass on my old ones. I've seen me snapping the needle off so they can't use it. Some people are happy to do that but I don't think it's right. I wouldn't have it said that I've passed anything on to anyone."*

In the following extract, Sally also made an important distinction between receiving used equipment and being present at the time that the owner passed it on, which indicates significant misunderstandings of infection risk. HCV is a

more robust and transmissible virus than HIV and very little blood is necessary for the spread of infection (Crofts *et al*, 1999). It has also been shown that sharing with an HCV positive individual can contaminate 70% of needle-syringes and 40% of other paraphernalia (Crofts *et al*, 2000). Koester (1994) suggests that 'needle transfer' or 'needle circulation' may be more appropriate terms since 'needle sharing' may imply a conscious, deliberate and reciprocal act.

Sally, 40 years

*"I didn't consider it at all at the time, though I have to say, I never shared a needle with anyone apart from Billy (partner). Sometimes used someone else's, but not sharing it. I mean that maybe someone had used it before, but not at the same time. So it wasn't like sharing. Though we did share spoons and all that. You see, I was used to being a volunteer at St John's Ambulance, and we learned about HIV and hepatitis then, so I knew it was dangerous to share the pins that still had blood on them. That was why I didn't share."*

Several women (12: 26) indicated that they perceived other drug users as different from themselves and made pejorative remarks about the cleanliness of those who might, for example, use contaminated needles (Plumridge & Chetwynd, 1998). Vitellone (2003) has commented that a moral statement can be made through the medium of discourse on personal hygiene and safety. The following extract indicates Jan's attitude to other addicts.

Jan, 30 years

*"I'd always thought they were dirty junkies, but until you get in among it you don't realise that there are dirty smackheads and some can be clean heroin users too. Well, for example, some will just use anyone's needle - pick it up from anywhere. I've seen lads use them when they've still got blood in the syringe and leave them all over the spot. Girls too, but not me, I always use clean".*

### **Influences of needle-syringe exchange services**

All of the women were aware to some degree of the North Cumbria Needle-syringe Exchange (NSE) facilities, which have been delivered through a Pharmacy-based Scheme since 1992. Local statistics relating to the scheme show that the ratio of male to female service users is approximately 3:1 (NCABS, personal communication, 2005). Carlisle was in the first tranche of NSE facilities which were piloted in 1987, and some drug agencies in North Cumbria are still able to offer a limited service. Less than half of the interviewees who injected heroin (12: 26) said that they had used the scheme and discussion

elicited a range of reasons, including inconvenience, fear of recognition and being banned from local pharmacies because of previous criminal activities.

Many women (16: 26) commented on the regular scarcity of sterile equipment, particularly those who lived outside the main towns where NSE is provided in a limited number of pharmacies. On the other hand, three women with a longer injecting career remembered the situation before any NSE were established, and declared that there was now no excuse for using contaminated equipment. In this extract, Moira portrayed the situation when she first began to inject heroin twenty years ago: drug injectors' desperation to secure any needles or syringes with practices which she now acknowledged were "like Russian roulette".

*Moira, 40 years*

*"I did try and get needles, but sometimes you just couldn't. If I didn't have a clean one, I'd just have to use what was there. But the thing was in those days, there wasn't needle exchange, and so it really was harder. Sometimes you just couldn't get them, and even the chemist wouldn't let you buy them. I mean, there was a girl round here, everyone knew who she was, who was diabetic, and everyone used to go to her bin and get them out of there. To even think of that now makes me sick, but that's what heroin makes you do. Me and a couple of friends often ransacked the bins, gave them a clean out, and that was us. I mean, I've been tested, but thinking back now to what I done, it was like Russian roulette."*

Difficulties in obtaining sterile supplies, seemed to be linked with concerns about lack of anonymity (Henderson, 1998; Mentor UK, 2004), and Neale (1998a) has affirmed this factor can be a barrier to effective harm reduction. The following extract illustrates some of the concerns other interviewees put forward, as well as the ways in which women consequently became more vulnerable.

*Sally, 40 years*

*"Well, my boyfriend was a registered drug addict and he used to get them from the Needle Exchange Scheme, and then I'd get them off him. I never went myself, I didn't want to be registered as a drug addict, mainly. It's all right for a man - it's much more accepted for a man to use drugs, but women are always condemned, so that's a big risk if you go to the needle exchange. It's in public at the chemist. It's not fair, but you'd rather avoid that risk. And I know lots of women who'd never consider using that, even though they need the pins. You have to find another way round it."*

This clearly demonstrated misunderstandings about the operating policies of the Pharmacy-based Needle Exchange Scheme, which hindered Sally's ability to access her own supplies. Barnard (1993) also highlighted this reticence to use

harm-reduction services, which could make women increasingly dependent upon others, often male partners. On the other hand, there were examples of good practice and a few women (5: 26) identified certain pharmacies where service provision was sensitive to their needs.

*Alison, 36 years*

*"There are times you get really embarrassed. There's one chemist that has got some respect for you. – she takes you down to the bottom of the shop where everyone can't see you. All the rest, they don't care and everyone stares. They should have a little room where you can go."*

A few women (9: 26) declared that they had decided to confront the difficulties they faced in remaining anonymous in a small town (Henderson, 1998; Mentor UK, 2004), and were aware of the issues for personal health protection.

Nevertheless, although more assertive, Nina keenly observed negative verbal and non-verbal reactions from some pharmacy staff, as this extract illustrates.

*Nina, 27 years*

*"I did think about it at first, whether I should go through to another town, so that people wouldn't know, but then I thought, it's my chemist in my town and I should be able to use it. The woman behind the counter shouldn't be gossiping and talking about customers, even though they're drug users. You can tell they think we're scumbags, but she shouldn't do it. I had to say to myself, I have to put myself first and use clean."*

For several respondents (8: 26) the provision of sterile supplies became a highly emotive topic and they expressed indignation that many young IDU living outside the main towns did not have equitable access to sterile equipment, or a means of disposing of used equipment: the following extract is one example.

*Sharon, 22 years*

*"You get them in the big chemist. I came into town and got them there. I didn't have a problem with that. I was in and out like a flash, mind. One thing that makes me angry is that there's nowhere in this place (small town). I think it's wrong that they don't have somewhere there, because I know loads of people who are sharing through there. It's a bus-ride through, and a lot of them just can't be bothered. Kids are finding needles all over the spot. I mean, I've never disposed of mine like that. I wouldn't put any kid's life at risk. But, I mean there isn't a proper place for them to get rid of them. People don't see why they should travel through. I know quite a few with hepatitis, loads in fact, now."*

Others women (3: 26) pointed out that weekend provision was limited to Saturdays, even in the pharmacies in town, and that supplies were subject to restrictions. Limits on the quantities supplied may aim to reduce injecting, discourage initiation or encourage more frequent attendance (NCABS, personal communication, 2005). However, some interviewees (4: 12) retained the view that this restriction consequently reduced the effectiveness of the scheme.

### **The influence of sexual relationships on sharing IDU equipment**

These preceding factors could be influential upon the women's drug-injecting risk behaviours, but it appeared that risk was also integral to their sexual relationships. It has already been noted that an addict dyad is a risk factor for women's initiation (Powis *et al*, 1996), and that female IDU tend to share injecting equipment with partners and close friends (Barnard, 1993; Dear, 1995). Some commentators propose that for women, sharing needles is an intimate demonstration of their relationship (MacRae & Aalto, 2000; Murphy, 1987). The overwhelming majority (28: 30) of women in this study had used heroin with a male partner for the main part of their drug-using 'career', and Holland and colleagues (1992a) have noted the premium status which society places on a heterosexual relationship. Establishing intimacy seemed to mandate an acceptance of sharing drug-injecting equipment, as well as the apparent disregard of personal risk. Sexual relationships can also be power relationships and some women may risk violent repercussions if they resist this sharing (Rhodes *et al*, 2001). There were consistent reports of sharing equipment with partners (22: 26) and assurance given that this was conforming to the norm, and was justified by this type of relationship. As the women progressed their heroin 'career' into 'inundation', the ensuing isolation from non-drug-using friends established new social networks. Such addict networks may be more likely to define acceptable joint risk-taking (Maher, 1998) and to circumscribe a woman's ability to make a safer choice.

It appeared that most women (22: 26) did not even account for their behaviour as sharing if it involved a male partner, as the following extract illustrates. Furthermore, a few (5: 26) declared that sharing with family or close friends was not perceived as carrying significant risk. Klee (1996) points out that

psychological salvation may be assured by the conviction that these individuals were 'safe'.

*Jackie, 22 years*

*"I've always used my own needles, really, but Eddie (partner) used to get them because I couldn't get in to the chemist in town where you can get them. You just get them as best you can. I've shared with my cousins, but they're clean. And I did share with Eddie."*

Other studies have shown that while women drug users tend to confine their sharing to partners and close friends, their male counterparts were more willing to share equipment with a wider social circle (Barnard, 1993). The women's narratives often revealed unquestioned confidence that their partners confined their sharing between them, and this high degree of intimate trust was remarkable. Such a commitment may divine meaning in consolidating their partnership, but most women (22: 26) claimed that sharing equipment was an accepted commonplace. In this extract, Moira accounted for typical beliefs.

*Moira, 40 years*

*"Yes, and we shared everything between us (with husband). Shared everything, needles, syringes, everything. But the way we were, we thought if we were sleeping together anyway, it couldn't matter much."*

Rhodes (1997) has argued that 'the everyday experience may be perceived to have functional benefits where actions may depend more on socialized habituation than on calculation'. It may be posited that for these women the risk of compromising their valued relationship outweighed the longer-term risks to their health, and mutual trust was said to be of central importance.

It often seemed that the risks attached to equipment-sharing were so generally accepted as the norm that they were rarely a topic of conversation, or even less negotiation, amongst couples. Kane (1991) has suggested that by keeping these issues silent, neither partner is required to acknowledge them and thus the *status quo* is maintained.

It was consistently reported by interviewees (22: 26) that male partners took charge of drugs procurement as well as their preparation, division, and administration: other studies have indicated that this may also predispose the

sharing of equipment (Bennett *et al*, 2000b; Klee *et al*, 1993; Powis *et al*, 1996). Women drug users' deference to male expertise (Klee, 1997), which was so frequently declared, may also have mandated an intimacy demonstrated by the joint use of injection equipment. It was revealed in this study that many women (22: 26) continued to be injected by their partners even although they knew how to self-administer heroin (Kral *et al*, 1999).

### **Influences of sexual behaviour on shared risks**

HIV may be transmitted by the mixing of bodily fluids, and an IDU who has become infected by sharing injecting equipment with other IDU, may also potentially introduce HIV to a partner by sexual contact. Efforts to combat HIV in the early 1990s encouraged the use of barrier protection as well as a reduction in the number of sexual partners. Although IDU were highlighted as being at high-risk of contracting and spreading HIV, there has been little evidence of consistent condom use, although changes in injecting behaviour have considerably reduced and maintained low prevalence amongst injecting populations (Donoghoe *et al*, 1989; Hartgers, 1989; Klee *et al*, 1990; McKeganey & Barnard, 1992). It seems that the use of condoms is rare within drug-using relationships and this dislike is expressed by both male and female IDU (Friedman *et al*, 1992; Klee *et al*, 1991; White *et al*, 1993). Rhodes and Cusick (2000) postulate that unprotected sex can be an intentional negotiated activity which is undertaken to defend the security and stability of these relationships, regardless of HIV status. Muller and Boyle (1996) found that for women in their study, maintaining heterosexual relationships and securing drug supplies were higher priorities than personal protection against HIV.

However, in this neglect of safer sex, women drug users may merely reflect the attitudes of the wider, though potentially lower risk, population, and Holland and colleagues (1990a) have commented that *'If love is assumed to be the greatest prophylactic, then trust comes a close second'*. Holland and colleagues (1998) have gone on to point out that young women remain under pressure to conform to what may be seen as conventional femininity and thus *'to aspire to a relationship, to let sex 'happen', to trust to love and to make men happy'*. They propose that for many women, exercising greater control over sexual health requires an enhanced sense of female agency (Holland *et al*, 1998).

An area of particular concern for HIV transmission, as well as HBV and HCV, is within the prison estate, where the sharing of injecting equipment, violence and unprotected sex between men are reported to be widespread (UNODC, 2005). The Prison Service has been reluctant to adopt harm-reduction measures such as needle-exchange since this is perceived to be in conflict with custodial and disciplinary duties, although methadone substitution therapy has recently been approved (Home Affairs Select Committee, 2002). Nevertheless, it has become apparent that this type of intervention within prison settings can lead to important harm-reduction benefits (Dolan *et al*, 2003). Furthermore, Butler and colleagues (1997) found that about a third of those received into Australian prisons were positive for HBV and HCV and have asserted the need for robust vaccination programmes. In the UK, modelling techniques demonstrate that if 50% of prisoners were vaccinated against HBV from 2006 onwards, the estimated number of cases of acute HBV in the IDU community could be reduced by almost 80% (Sutton, 2006). All but one of the women in this study identified herself as heterosexual and many of their partners (16: 28) had been, or were currently held in custody. Since it has been estimated that 60% of IDU pass through the prison system at some stage (DH, 2004a), it may be deduced that their partners may be at increased risk through unprotected sexual contact with prisoners on release. Conventionally, women have been deemed responsible for negotiating contraception (Holland *et al*, 1992b; Richardson, 1990), but many newly-released prisoners and their partners may not have considered this particular need for barrier protection.

Interviewees were unanimous in their dislike and rejection of barrier protection, although all were aware of the potential for infection, and this has been found in other studies (McKeganey & Barnard, 1992). Cumbria fortunately has low prevalence of HIV infection but the risks of complacency are high. Women accounted for their neglect of protection in diverse ways: apathy; avoiding acceptance of sexually-transmitted risk; and deference to the prerogative of a male partner. Some interviewees (10: 26) acknowledged the potential impact upon their own drug-injecting behaviour of knowing other IDU who were HCV positive, but the low prevalence of HIV in Cumbria may have fostered a false sense of confidence about other routes of infection. Interviewees (22: 26) indicated that lack of sexual health prophylaxis was often premised on a belief

that their relationship was monogamous, and Sally illustrated one such example in the following extract.

*Sally, 40 years*

*"I've had tests for Hep C and I'm clear, so that's good. There's not much trouble with HIV round here. When I started going with my current boyfriend, he's a user the same as me. I said to him 'No offence like but I'm going up to GUM to get tested and I want you to come with me'. Then we'll know that we're clear so then we could forget all about condoms and that, horrible things anyway."*

It has been argued that disclosure of a partner's sexual history and sero-status are important strategies for health protection (Rhodes *et al*, 1993). The overwhelming majority of interviewees (26: 28) were adamant that it was a risk that they were prepared to take, pointing out that in any case a new partner would be reluctant to prejudice a relationship immediately.

Many interviewees (17: 28) who were in addict relationships proposed that the prime reason for not using protection against the risk of HIV infection was their partners' dislike of condoms, as well as his annoyance at the suggestion of using them. In this interviewees are probably no different from other heterosexual women who may have partners with a lower risk of HIV, and the difficulties of negotiating safer sex and drug use without compromising a relationship have been well documented (Holland *et al*, 1990b; Klee, 1997; McKeganey & Barnard, 1992; Rhodes & Quirk, 1998). Several women (13: 28) said they had suffered abuse and violence from their partners, and fear might affect their ability to introduce condoms into an established relationship. Sexual relationships can also be power relationships and this additional influence will be described in a subsequent chapter.

It became clear from discussions about condom use that some women (6: 30) chose to associate barrier protection with contraception and their sexual health prophylaxis was consistently ignored. Apart from the two women who had worked as prostitutes and had attended Genito-Urinary Medicine (GUM) Clinics, none of the women recalled discussing sexual health issues with a health professional. One interviewee explained that there was no need for barrier protection because she used the contraceptive pill, and another said that it had

seemed unnecessary because she had been surgically sterilised fifteen years previously. Elaine's opinion in the following extract was typical of a commonplace belief that heroin adversely affected fertility.

*Elaine, 24 years*

*"No, I've never got them. It probably sounds terrible, but that never seemed very important to anyone. I've had an awful lot of unprotected sex, but people think if you're a heroin user, well into it, you're not likely to get pregnant anyway."*

Some women (3: 30) excused their neglect of personal health protection as due to low self-esteem or depression, which can often lead to the 'learned helplessness' of vulnerable individuals in abusive situations (Seligman & Maier, 1967).

Pauline proposed this influence on her attitude to risks to her health and well-being, and it has been said that many women drug users experience depression (Farrell *et al*, 1998). Other women (8: 30) chose to blame heroin-induced apathy for their neglect of this area of health protection.

*Pauline, 39 years*

*"Well, I didn't know much. It's only a few years, four or five years, since I thought about risks for myself. I didn't know about anything really. It must have been there but I never really took it in. And with being depressed it didn't seem to matter that much. If I carried on like last year with the depression and the heroin and Diazepam, I'd be dead and gone anyway."*

Lex (1991) has proposed that the greater stigma accorded to women who use illicit drugs results in an increasing tendency towards depression, and this has been corroborated by other studies (Farrell *et al*, 1998; Griffin & Mirin, 1989; Reed, 1985).

## **Summary**

Interviewees' accounts indicated the complexity of the myriad risks attached to their use of heroin. These risks ranged from those attached to sharing the lifestyle which were summarised in the first section of this chapter, to the potential for serious infection and illness which was influenced by their shared drug-injecting and sexual behaviour. Giddens (1991: 109) has remarked that *"To live in the universe of high modernity is to live in an environment of chance and*

risk', and it seemed that for many women drug users their lives were characterised by disadvantage, uncertainty and the likelihood of misadventure (Carlson, 1996).

Some interviewees claimed to be naïve of this possibility of infection and disease but many chose to ignore the risk, apparently preoccupied with competing demands. Rhodes (1995; 1997) has argued that the lives of drug users are permeated by danger and that they may often prioritise risks which are not *'epidemiologically important, but a product of socially-situated risk perceptions'*. Risk and health-related behaviour may therefore be seen as socially interactive processes derived from, and mediated by, the practical realities of drug-users' lived experience (McKeganey & Barnard, 1992; Rhodes & Quirk, 1998). It has been argued that effective harm reduction for drug users must recognize the influence of personal relationships as well as the known contextual factors (McKeganey & Barnard, 1992; Rhodes & Hartnoll, 1996; Rhodes & Quirk, 1998).

In this study, it seemed that the practical benefits to using heroin as a couple had to be constantly balanced and negotiated against the inherent risks to health, reputation, employment, childcare and other close relationships. Isolation from non-drug-users was said to have further enmeshed women in this *'apprenticeship'* stage of their drug-using *'career'* (Rosenbaum, 1981a), but on the other hand, a shared heroin lifestyle could offer excitement and often membership of a group. It was portrayed that sharing risk arose out of a complex interplay of individual and socio-cultural circumstances, but this was often underscored by the expectations of heterosexual custom and practice.

Interviewees often indicated the constraints and boundaries of the private rules and norms of their relationships. At an individual level, some women acknowledged the potential personal and health risks they faced, and made efforts to minimize the harm by trying to obtain sterile injecting equipment. It appeared that some women experienced difficulties in accessing sufficient independent supplies, and this situational factor presents an unacceptable impediment to harm reduction. Interviewees claimed that they had concerns about the risk of public disclosure of their illegal drug use, and some proposed

that environmental factors were influential on keeping their addiction secret (Henderson, 1998; Mentor UK, 2004). In a few cases, ambiguities and misunderstandings about the crucial details of potential for BBV transmission were identified and remain a concern, and there is a risk in areas of low prevalence for HIV that this may foster complacency. Indeed, most of the women (22; 26) conformed to the accepted norm in drug-using circles of sharing injecting equipment with a partner, and interviewees said that BBV transmission though unprotected sex was not a major concern. Knowledge alone was clearly insufficient to protect, and initiatives targeted at individual behaviour are therefore unlikely to be effective. Interventions to influence group norms, for example, within service user groups, and by wider social skills development for drug users, may provide more sustainable and effective benefit.

In addition to these explanations of social context and structure, Giddens (1991) has said that individuals faced with high-consequence risks that seem distant from their daily lives may '*bracket out*' the dangers they present because they are too remote to be seriously contemplated. It was evident that women's individual risk assessment regarding the use of heroin, and its links with infection and illness, was strongly influenced by the social context in which they adapted and lived their lives. It seemed, according to Giddens' (1991) notion of '*practical consciousness*', that the functional benefits of conforming to the norm outweighed any potential dangers. He also called on the notion of '*a protective cocoon*', which filters out harm from the '*external world*', and declared that shared histories and basic trust within a relationship can provide this necessary security. Within this '*cocoon*', individuals may still remain sensitive to a continuum of risk assessment which, he suggests, is encompassed by Schutz's (1970) '*system of relevances*'. According to Schutz (1970), it becomes necessary to create a '*moving wave front of relevance*' in which a range of dangers can be judged according to their significance. These concepts may also assist in explaining risk behaviour in the context of women drug-users' everyday lives. It may be construed that drug-using women may employ similar strategies in high-risk situations, in order to preserve the security of their valued social, and particularly sexual, relationships. Some commentators have pointed out that such relationships can assume prime importance for drug-using women (Hyde *et al*, 2000; Unger *et al*, 1998).

Furthermore, these concepts can be underpinned by the influences of social exclusion, and individuals who have a diminished sense of control over their lives may use the management of such risks as a means of developing self-identity (Lupton, 1999), or more pessimistically, because of limited choices and a bleak foreseeable future. A nexus of socio-cultural influences may therefore be seen to operate, and to compromise the likelihood of an individual choice being made to minimize the '*risky business*' of heroin use. Women frequently emphasised that these socio-cultural influences could contribute to the development of their drug use, but that the decision to become involved in heroin use was theirs alone.

In considering the risks attached to their drug use, interviewees often raised issues about the influence of relationships, including that with sexual partners and friends, and the next chapter will now appraise these factors.

## **Chapter 4**

### **Relationships: Influences and risks**

#### **Sexual partners and Friends**

This chapter will account for interviewees' views about personal relationships and their significance in relation to their problem drug use, and will consider the influence of both partners and friends. It will describe the variety of ways in which heroin both seems to affect and be affected by drug users' relationships, and will provide insight into some of the attitudes and values held by interviewees.

Illegal drug use has been recognized as a social phenomenon in which the behaviours involved may communicate interpersonal meanings (Bloor, 1995; Bourgois, 1997; McKeganey & Barnard, 1992; Rhodes, 1997). The previous chapter has described context-dependent practices related to sharing and risk, which may gain a symbolic function in maintaining the '*status quo*' of drug users' social and sexual relationships (Kane, 1991; McKeganey & Barnard, 1992; Murphy, 1987; Zule, 1992). The findings of this study have recognised the complex influence of '*significant others*' (Berger & Luckman, 1966) in the development of interviewees' drug dependence.

#### **Risk behaviours linked with sexual relationships**

Social relationships have been identified as an important type of structure to gain insight into drug users' risk behaviour (Friedman *et al*, 1992; Ncaigus *et al*, 1994; Sibthorpe, 1992), and it has been asserted that drug users' sexual relationships represent a key '*site of risk management*' (Rhodes & Quirk, 1998). The intrinsic dynamic of negotiated actions between individuals within the private sphere, but under the influence of wider social and cultural norms appears to intensify the potency of such relationships (Holland *et al*, 1992b; Lupton, 1993; Rhodes, 1997). Rhodes and Quirk (1998) have argued that managing an ongoing sexual relationship is in itself a form of risk management,

and for drug users has additional complications in that the demands of addiction may frequently assume a greater priority. Inherent risks emanating from drug use within a relationship include: greater proximity to heroin and a tendency to equalize consumption; a drug-using social circle; drug-related conflict over sharing resources or decisions to quit the use of drugs; and heroin's impact on sexual communication. There can be particular difficulties experienced if one partner is a non-user and issues of trust can then become salient. Risk management in terms of relationships may be seen to depend on trust between partners, intimate disclosure and the absence of discord (Giddens, 1992), which is often in conflict with a drug-using lifestyle. Rhodes and Quirk (1998) stress the importance of drug users' recognition of the risks to their relationships from addiction, and the socially interactive nature of both of these risks, often operating under considerable tension. Paradoxically, it has been asserted that social relationships provide a context for effective interventions to reduce risk behaviour (Rhodes & Hartnoll, 1996). These risks could therefore affect either partner, but since this study focussed on the influences upon this sample of women drug users, the next section will review some of the evidence about female gender-specific risks within sexual relationships.

### **Gender-specific risks**

Drug-using sexual partnerships appear to be characterized by collaborative efforts, as well as the utilization of individual skills to develop shared drug-using 'careers' (Rosenbaum, 1981a; Taylor, 1993). This context is of particular relevance for women drug users because the majority forms a relationship with a male counterpart (Cohen, 1989; Dwyer *et al*, 1994; Freeman *et al*, 1994; McKeganey & Barnard, 1992; Neagius *et al*, 1994; Rosenbaum, 1981a), whereas men who use drugs tend to develop liaisons with non-drug-using sexual partners (Donoghoe, 1992; Kane, 1991). It appears that for many women this develops into a 'drug bond' (Kantor & Strauss, 1989) linking drug use and relationship, and often becomes a source of both comfort and conflict. It has been observed that for women, drug use within a sexual relationship may be more tolerable, not only to themselves but also to partners and the wider community (Barnard, 1992; MacRae & Aalto, 2000). Ettorre (1992: 21) has remarked that '*dependent*' has either a meaning of '*addicted*' or '*subordinate*', and that '*to be addicted is socially unacceptable because it interferes with the woman's role as housewife, mother, daughter and worker, while subordinate is*

*valued and accepted when it involves being dependent on men*'. Ettorre (1992) also contends that some women may feel 'more in control' by being under male jurisdiction and thus having their drug use regulated.

Women drug users are more likely to be injected by men (Gore-Felton, *et al*, 2003; Macrae & Aalto, 2000; O'Connell *et al*, 2005), or to have assistance doing so, which has been asserted to be predictive of HIV infection (O'Connell *et al*, 2005). Others have also noted that within drug-using couples, the widely-accepted division of labour of addiction can offer women protection from public scrutiny and official discovery (Barnard, 1993; MacRae & Aalto, 2000). Amongst women, a heterosexual relationship still appears to be the most highly valued (Holland *et al*, 1992d), and can offer some status and stability for female drug users who may already feel stigmatized (Barnard, 1993; Rosenbaum, 1981a). It has been posited that intimate relations assume great importance in women drug users' lives and may often surpass any concerns about blood-borne infections (Hyde *et al*, 2000; Unger *et al*, 1998).

Furthermore, it has been pointed out that disparities in social and economic power between partners can circumscribe women's ability to negotiate safer sexual and injecting practices (Amaro, 1995; Metsch *et al*, 1998; Stevens *et al*, 1998). Social attitudes towards male and female sexuality are deeply held and enduring (Dennison & Coleman, 2001), and it has been claimed that women are expected to adopt a passive role in deference to the male prerogative (Moore & Rosenthal, 1993). Kane (1991) has remarked that drug-using women may thus place themselves at risk within their relationships by reproducing conventional feminine subordination within a heroin sub-culture. Interviewees often accounted for the dynamic of power within their relationships, and aspects of this influence will also be described.

The following section will review the women's accounts of their relationships with sexual partners and will consider the issues they raised. These accounts provide insights into what it meant to use heroin within a relationship: the effects of the drug upon sexual communication; the way it could create a bond between the couple; or could mediate the dynamic of control and sometimes abuse; it could create the need for deception; and could also generate concerns about the fragility of a union enmeshed with heroin.

### **Relationships with addict partners: influences and risks**

Nearly all (28: 30) of the women in this study had at time been in a relationship with a male heroin user, often in series. Some interviewees (8: 28) had ever been or were married (4: 8) to him, although most women (24: 28) had ever been or were (6: 24) co-habitees. Most of the women (22: 28) had ended relationships in their efforts to try to quit drug use, and some of these women (6: 22) mentioned that domestic abuse had been an additional factor. Some of the women (4: 22) said they had gone on to develop new addict liaisons, and often linked this pattern with relapse.

Interviewees proposed motives for using heroin with a drug-using partner and these were not mutually exclusive. These factors included: a desire for affinity; to facilitate access to drugs, particularly if he was a dealer; to avoid censure and rejection by non-drug-using males; for protection and security; and to hide their drug use from public scrutiny. A few women (3: 30) were currently associating with men who claimed never to have used drugs, and they also explained the complexity of this particular situation.

Many interviewees (19: 28) said that they were aware that using heroin with a partner had become the basis of their relationship, and they often remarked on the potent symbiotic link. Most interviewees (22: 28) pointed out that they believed this could be so strong that eventually a dilemma emerged, requiring a choice between the two of them. Moira's sad reflections were typical of the majority of those interviewees (22: 28) who decided to terminate their relationships as part of a strategy to try to cease drug use.

*Moira, 40 years*

*"Heroin made the relationship (with husband). It made our life together even though it was hard work sometimes, ducking and diving, police and that, but wrecked it all in the end."*

Conversely, some other women (4: 28) claimed that the affinity and shared challenges of pursuing heroin use together, and then subsequently struggling to manage drug treatment, strengthened their bond. Despite the fact that most women (22: 28) had now ended relationships, they had no hesitation in describing the qualities which had initially appealed in their partners, and the factors that had established *rapprochement*. This provided compelling insight into the

meaning of this relationship as well as the values held by interviewees, and indicated the priorities which were relevant. The women frequently used adjectives such as "nice", "lovely", "bubbly", "kind", "loving", "caring", "strong", "trusted", "protective" and described him being "fun to be with", "good for a laugh"; "interested in me"; "I can look up to him"; "good head on his shoulders"; "knew the ropes"; "there for me"; "best mate"; "we were equals"; "from a good family"; "looked after me"; "makes me feel like I'm normal" or "makes me feel really safe, really secure, really wanted". There was admiration for men who were perceived to be "a bit cool", "a hard man", "bit of a bad un" or one who "could run rings around anybody". More pragmatically, some women's thoughts turned to the worth of having someone "I could trust to be there if I overdosed", or "who'd be able to catch me if I was to fall," or "also selling drugs, so that made him all the better, and I liked him even more for that". Conversely, some interviewees (8: 28) now spoke with vitriolic contempt of men whom they now believed had manipulated them into elevated heroin use, and had then used the women's drug dependence as a means of control.

Some interviewees (7: 28), who often said they were in serial relationships with addicts, made it clear that they had actively sought a drug-using partner. Sometimes it was revealed that this could increase access to heroin, but Ellie explained that choices for women drug users could soon become circumscribed, and restricted by male attitudes to female addiction.

*Ellie, 23 years*

*"You tend to go with a lad who uses. It's probably two things. You tend to go with a lad that isn't going to try to stop you. And you don't want to have to worry about them finding out either. Lads don't like to go with girls that inject anyway. They judge you as something like a slag and look down on you. It's a big thing feeling that you're worthless - you don't need everyone else telling you that too."*

Key elements of a relationship were also said to be caring and sharing, and this could relate to self, activities or resources. The previous chapter has already highlighted potentially high-risk practices involved in shared drug-related activities with a male IDU, as well as the potential sequelae of criminality and infection or disease. Another impact of this shared lifestyle was said by most interviewees (23: 28) to be an escalation of their heroin use, and it was frequently explained that as a result of using the drug within an addict relationship, they had "really got into it then" (Almog et al, 1993; Hser et al, 1987;

Klee, 1996; Rosenbaum, 1981a). Gemma was one of those interviewees who described the powerful effect of living with an addict partner, but it must be acknowledged that a male drug user might experience a similar increase in consumption when using heroin in the company of a female counterpart.

*Gemma, 27 years*

*"He'd moved in with me here, just after I started injecting. So there was him using in my house, and all this heroin around us, it was just impossible not to use more than you meant to. And I would think, 'I want to get my fair share if all this is coming into my house.'"*

In Gemma's situation it appeared that a contributory factor had been the regular availability and supply of the substance, but it may also be surmised that the close association of daily living must have encouraged interest and commitment to drug-related activities. Interviewees went on to elaborate on other aspects of using heroin within a relationship, and one of these was sexual expression.

#### **Influence of heroin upon sexual communication: "a kind of intimacy"**

More specifically, Carol articulated the way in which the sensuality of sharing the administration of heroin intensified her relationship with her husband, especially as it could compensate for the drug's physiological effects which may impede sexual communication (De Leon & Wexler, 1973). Rhodes and Quirk (1998) argue that this is a specific area of relationship risk management for drug users, often requiring 'going through the motions' or, as in this case, an apparent substitution of sexual relations.

*Carol, 42 years*

*"But this was the one area where we could be very open with each other. I think that using drugs was a kind of intimacy. If you're using heroin, there isn't much of a sex life. We shared well, a sort of intimacy, in just sitting around and using our drugs together. The one thing people commented on was what a solid couple we were."*

Others took a less positive view of the effects of opiate use and this is typified in Pauline's recollections of the impact of heroin on her marriage. It has been established that heroin use often lessens libido, diminishes sexual capacity or reduces sexual arousal (Crowley & Simpson, 1978; Klee *et al*, 1990; Rosenbaum, 1981b; Smith *et al*, 1982). However, other studies have reported high levels of risky sexual behaviour amongst heroin users (Rhodes *et al*, 1994), and this seems to be linked with the severity of addiction (Gossop *et al*, 1993).

Nevertheless, many addicts report less sexual activity than non-drug-users (Mirin *et al*, 1980), and some (5: 28) interviewees chose to mention this feature of their relationships.

*Pauline, 38 years*

*"Well, the drugs have affected everything, as it's gone on more and more. Me and my husband don't talk as much as we used to. But perhaps we understand each other more, so we don't need to talk, in a way. We don't have a sexual relationship and that's down to the heroin. No affection, cuddles, no nothing, not for a very long time. I do trust him still mind, we haven't got the energy to be unfaithful anyway. You know at one time I used to bother with makeup and nice clothes and skirts and all that. Now I just can't make the effort. I don't know if he'd notice anyway. When you're in that state, you're just like being on your own, in your own little world."*

Wellisch and colleagues (1970) observe that the virtual absence of sexual relations can result in a sibling-type of bond, in which there is inter-dependency in terms of both procuring drugs and providing protection. In the following extract, Gillie described similar features of her relationship.

*Gillie, 21 years*

*"I loved him (partner) to bits – still do really. We were best mates, like brother and sister – looked out for each other and whatever. He was a year older than me, I left home when I was sixteen to move in with him. But when we got into the heroin things changed – there was no kissing or anything, no sex. Didn't have a bath or nothing – it was just the heroin. Couldn't get up in the morning without thinking about shoplifting and that."*

Mutuality could be affirmed in the pursuit and use of heroin and it appeared that the partnership rules of sharing (Grund, 1993; Wieder, 1974) also became symbolic of trust and solidarity within the women's relationships, as Carol went on to explain.

*Carol, 42 years*

*"It was a special sort of thing, the trust. We'd (Carol and husband) just get out what we needed and split what we had down the middle. I got up to using just what he (husband) did very quickly. If he ever scored and I wasn't at home for any reason he might sometimes have half and leave half for me coming home. We really looked after each other, a good relationship, didn't use to argue about much at all."*

However, when there were instances of betrayal around sharing, Carol said it became impossible to sustain the relationship, and other (8: 28) women presented this as a prime source of discord. Rosenbaum (1981b) highlighted the

undermining influence of heroin dependence on an addict couple's relationship, and portrayed similar duplicity as tantamount to sexual infidelity. In the following extract Carol indicated the source of her discontent.

*Carol, 42 years*

*"But sometimes I didn't think it was half because of his greed. He (husband) would divide up and I knew he wasn't doing it fairly. I mean there were times I'd got the money and got it fairly, worked for it. I'd done some fraud and deception, but not that much. But the truth is I did want to be in control: that was only fair. I didn't like the feeling of him being in too much control eventually."*

### **Influence of issues of power and control**

Power and control were recurrent themes in the women's accounts of drug use within a dyad, and were frequently mentioned to be influential. It has been said that gender inequalities are widespread throughout society and are integral to the organization of its economic, political and social institutions (Bajos, 1997): Ettorre (2004) argues that they are '*embedded in society*'. Chodorow (1971) has asserted that feminine roles are about '*being*' a mother, wife or daughter, whereas masculine identities are bound up more with '*doing*'. Furthermore, Bell and Newby (1976) have commented that women tend to be socialized into caring and supporting, whereas there is a tendency to expect men to protect and provide. Bell and Newby (1976) investigated the concept of deference paid by women to men, which they suggest is widely sanctioned both by culture and religion, and is symbolically reinforced by the provision of gifts. The study of gifts as a type of intrinsic gratification, which requires no calculation of equity or negotiation, has been considered for many years (Malinowsky, 1922; Mauss, 1954). Furthermore, according to Mauss (1970: 72) '*to accept without returning or repaying more is to face subordination*', and interviewees frequently accounted for a secondary role in shared drug-taking episodes. In this study, it seemed that the '*gift*', as an intrinsic gratification, was exemplified by partners providing women with the sensual experience of heroin, even though many interviewees said they had developed the skills to self-administer. This practice appeared to be peculiar to an addict sexual relationship, since some women (3: 26) reported that recompense was required if another drug user performed the injection or obtained supplies of heroin (Carlson, 2000). Dependence on male prowess to score and to take control of the preparation of heroin was also presented as

having a symbolic meaning. In the following extract, Sara provided insight into her need and preference to depend on her boyfriend's skills.

*Sara, 26 years*

*"It was because he (partner) was the expert about it all but also I think it meant that I needed him to get that sensation. Me, I always need somebody else. I thought the world of him, I wanted to be with him, do what he did. I respected how he knew about things. I trusted him to do everything look after me. You have to don't you? It's one and the same thing. But he let me down big time."*

Within sexual relationships, it has been argued that these gender inequalities can be replicated in terms of 'emotional labour' (Graham, 1983), and that a power imbalance can derive from an unequal exchange of resources including money, physical strength or sexual attractiveness (Connell, 1987; Dunscombe & Marsden, 1995; Eichler, 1981). Furthermore, it has been said that: where earnings are unequal; women are entirely responsible for childcare; femininity is defined by submissiveness; and the male prerogative is dominant; then sexual relations are not the outcome of open negotiation (Holland *et al*, 1992a; Holland *et al*, 1992b; Ramazanoglu, 1994).

Moreover, Maxwell and Boyle (1995) have noted women's self-coercion when they comply with male demands. They allude to Gavey's (1992: 327) assertion that '*women may be persuaded into apparent complicity in our own subjugation*', which draws on Foucault's (1979) concept of 'disciplinary power'. Gavey (1992) goes on to point out the subtle complexity of this influence, remarking on Bartsky's (1988: 72) observation that '*a panoptical male connoisseur resides within the consciousness of most women*'. In addition, it seems that any discussion over potential risks may raise issues of trust and loyalty which can challenge the stability of a relationship (Aalto & MacRae, 1997; Bajos, 1997; McKeganey & Barnard, 1992). These societal expectations of male superiority and female dependency have become pervasive (Moore & Rosenthal, 1993), and resonate with interviewees' stated partner preferences and expectations of their relationships.

In proposing qualities which they themselves brought to the relationship, some women (6: 28) perceived it was their "*duty to help him*", for example to find a vein, recover from overdose or attempt abstinence, particularly if she was aware of "*his own troubled background*" and he needed care and sympathy. '*Emotional*

*labour* as a concept and the caring role implied was defined by Graham (1983: 29) as being *'performed on people and providing the basis by which women negotiate their entry into intimate relationships as well as wider society'*. Whilst acknowledging that this role may provide self-esteem for some women, Jackson (1995) argues that it may encourage exploitation, and can serve to widen any gender inequality gap. Several interviewees (11: 28) articulated their own reservations about this conventional feminine supportive role, and often in their narratives there was resentful comments of *"he took charge of everything"* and *"I had to follow his wishes"* and that he was *"very demanding"*.

As an illustration of these demands, Gemma spoke of her irritation at the traditional values her husband retained, and his apparent selfishness when she was occupied with attending to the needs of their children. This produced tension in her relationship both with Mark (husband) and with her mother-in-law, and in this extract she described the context of her discontent.

*Gemma, 27 years*

*"But when you know him (husband), he's really loving and caring and he loves us to bits. Almost too much, at times, because it can be a bit overpowering, he likes it all his own way. His mum's always been the big thing. It's an Irish family, really strong family values, adores his mum and she does everything for him. Even if she was having her tea, she'd drop everything to make something for him, if that was what he wanted. There are times when I think he's expecting me to do the same. I mean, it's like having three kids: one's 33, one's seven and one five months. He's not like a New Man, he will do it eventually, but he's got to be asked. Very traditional, like, I understand where he's coming from, I just wish he'd help me out sometimes, though."*

Taylor (1993) remarked upon similar resentment of inequalities by the women in her study, but remarked on interviewees' general acceptance of male dominance and domestic abuse: a phenomenon extensively documented in the literature (Barnish, 2004; Dobash & Dobash, 1979). In particular, there seems to be a high rate of victimization among women substance misusers, which apparently increases with the severity of addiction (El-Guelbaly, 1995; Jacobs, 1998; Miller *et al*, 1989), and can intensify the sequelae of women's ill-health (Liebschutz *et al*, 1997). Interviewees did not always describe this abuse as physical violence, but Nina claimed that the impact of mental and emotional cruelty had been more enduring. In the following extract, she described her partner and the outcome of his offensive behaviour on her self-esteem and confidence.

*Nina, 27 years*

*"Violent and abusive. I now know he's (partner) just a bully and intimidating. Really, really jealous. Just wanted to know what I was doing the whole time. We just used to meet at weekends, but then his girlfriend found out and threw him out. Then he moved in with me, and then everything changed. He did lift his fists a few times, but it was more mental cruelty, psychological, I think you'd call it. He was always, always putting us down, and it drains your confidence."*

Nina went on to explain that her own recognition of this situation as self-inflicted misery had prolonged the abuse, and had even escalated her heroin dependence. Philip and colleagues (1997) have commented that women drug users are often very reluctant to seek help in these circumstances. In the following extract, Nina explains her own understanding about, and attitude to domestic abuse.

*Nina, 27 years*

*"I really thought it was all part of the picture of being a drug user, and you just had to get on with it. The drugs sort of softened the pain of it all, and I know lots and lots of girls in the same situation living with someone as violent as that. Women that use drugs often end up with bad uns that abuse them and beat them up. I thought it was what I'd taken on - my choice."*

On the other hand, a couple of women had developed coping strategies to remove violent men from their home situation. After years of serious physical injuries, Lara had successfully used a Court Order to remove her former partner from their home and knew how to organize this again. Nevertheless, she still admitted living in fear, particularly since her former partner had recently been released from prison and had returned to the area. In the following extract, she described a recent incident when he had taken the chance to threaten her again.

*Lara, 28 years*

*"Sean's (former partner) been to the house, but I'm feeling a bit edgy about it all. I mean, he's been away and suddenly back, and I'm scared what might happen. I mean, a few weekends ago, I was in the local club for a drink with a crowd of friends, and he saw us, didn't like it and dragged me out. Threw my shoes away and put me in a car and then threw us out in the road outside my house. So I got him locked up and he was served with a harassment thing, so that put me back on my ladder again because I'd done something about it, taken charge. I've found that my injunction is now void, though, and I've got to go through that whole thing all over again. I don't think it's fair."*

Another woman used less orthodox means of escaping a violent partner, but Sue claimed that subsequently resorting to prostitution to support both herself and her child had just meant a return to a violent lifestyle. Sue described the extent

of the injuries inflicted by this violent man, as well as her isolation and despair about finding help and support from local agencies.

*Sue, 32 years*

*"No, it started when I moved in with him (partner), and if he had no gear or tablets or anything, he just let fly. I was black and blue many a time, and really injured, again and again, caused me to have a miscarriage and nearly beat the life out of me. Nobody would want to help me, or that's what I thought. The only thing I could think of was grassing him up to get him locked up again, and it worked. He'd broke his parole, you see, and I got rid of him. But the next thing was, I only got more violence, because then I had no choice but to work on the streets. One lot of violence to another. It was a tough time."*

In several (8: 28) of the women's narratives there was reference to the supply of heroin being used by partners as a means of coercive control and it was claimed that once the women had become dependent on heroin, abuse had become a feature of their relationships.

One interviewee now believed that cultivating her growing heroin addiction may have been a deliberate ploy by her husband to maintain the power balance in their relationship. Raine (2001) has suggested that this type of response may be linked with a male desire for 'exclusive ownership' of his partner (Dobash & Dobash, 1998), and Thom (1986) has noted that this misuse of power can impede a woman's efforts to seek help with addiction. In the following extract, Alison shared her insight and opinion that she had been subject to manipulation by the control of her drug use.

*Alison, 36 years*

*"He (husband) had all the control of me then. He had what I needed and he made sure he'd got me on to it. He didn't like me injecting though I suppose because it's much more serious, perhaps he thought he'd catch something off us. I don't think he was protecting me really. If I was tooting I think he felt more in control and I was more dependent."*

This dominant role exercised by male drug users has been extensively documented (Daly, 1992; Gossop *et al*, 1994; Sargent, 1992). Women's habitual deference to male expertise in procuring and administering drugs may place them at additional risk (Barnard, 1993; Powis *et al*, 1996), and once dependence is established, they may become increasingly vulnerable to abuse. Cindy even seemed to delight in self-deprecation of her inexperience compared with her

partner's proficiency with heroin, apparently disregarding any potential harm or mischance which this subordinate position might induce.

*Cindy, 17 years*

*"He (partner) always kept me at a distance from it all – because my hand shakes too much he said. I remember at first I used to help and I thought 'That spoon's dirty' and I gave it a wipe. And he said 'Look what you've done, that's you wiped off your hit'. He was a bit mad at me. (laughs) So he always mixed it up and told me when it was ready. He took charge of everything, always, him first and then he sorted me."*

### **Influence of heroin use: "Bickering relationships"**

Rosenbaum (1981b) has argued that heroin can erode relationships in three fundamental ways because: it becomes the couple's principal focus and eclipses any other interests; it disturbs traditional gender-role expectations, especially if prostitution became a fund-raising necessity; and because financial strains and duplicity caused constant quarrels. In this study, there was universal agreement that a mutual interest in heroin became fervent and exclusive, but the disruptive effect of prostitution on relationships was not evident. Most interviewees (20: 28) did make reference to the negative effect of some type of "bickering relationship" as a consequence of joint heroin use, and the following sub-section will account for the issues highlighted in the women's narratives. Rhodes and Quirk (1998) have identified heroin's 'irritable effect' and that money and the sharing of drug supplies can become sources of 'scag fights', but many interviewees (15: 28) proposed that conflict was more often linked with a disparity in readiness to quit heroin use.

One such example was Elaine, who explained that her own unwillingness to end her shorter drug-using 'career', meant leaving her partner of three years to enable him to commit to treatment. She intimated that they had shared other interests before her drug use had become problematic, but her heroin addiction now assumed paramount importance, and with some reluctance, she had terminated their relationship.

*Elaine, 24 years*

*"We (Elaine and partner) used to go out for drives and fell-walking and that sort of outdoors kind of thing. We both liked the outdoors. He (partner) used to do some work on our family's farm, in fact he looked after it when Mum and Dad were on holiday. Heroin was his downfall, and mine, too. He got a DTTO just before I left him, because at the time he was ready to stop and I wasn't. It just doesn't work*

*like that, one wanting to and one not. He wanted to be clean, and I wanted it to work for him, and not hold him back. If I stayed, I'd just have dragged him back again. We'd tried it before, again and again, and it was me that wasn't ready, not him."*

Other arguments between couples were linked with the criminality associated with a heroin-using lifestyle, and Gemma explained that soon after their wedding Mark had been arrested for supplying heroin, and the two year wait for Crown Court trial had produced mounting tension. Gemma believed it was her responsibility to take on the supportive role, even though she was currently being treated for post-natal depression, and this resonates with studies of women in the general population (Graham, 1983; Brown & Harris, 1978). Ettorre (1989: 105) says that *'in the private sphere, women, particularly mothers have been shown to be the primary emotional copers, at potential risk to their physical and emotional well-being'*, and argues that this societal attitude may have particular relevance for addicts perceived as *'polluted'* women who use drugs.

In the following extract, Gemma shares her feelings of frustration at husband Mark's lack of emotional sensitivity, and it has been asserted that this type of conflict is reflective of gender-specific ideologies of personal relationships (Duncombe & Marsden, 1993). Furthermore, Duncombe and Marsden (1993) have observed that women prefer to rationalize their partner's behaviour by considering that their own expectations were unreasonable, and that this mediation of emotional intimacy can become another manifestation of gendered power (Duncombe & Marsden, 1993). Gemma went on to describe the way that their relationship had become increasingly quarrelsome as they both waited for the outcome of the trial at Crown Court, and that she bore responsibility for creating a congenial atmosphere.

*Gemma, 27 years*

*"All we do is argue or not speak. And he (husband) says, 'Oh no we don't' (laughs). That's the thing about Mark, he has this rose-tinted view of the world, doesn't see any problems for what they are - thinks everything is hunky dory with us, and I think 'Well, I don't' He's lovely, really, it's all just getting strained with this Court case. To tell you the truth, this is what's getting to me. I mean, if it's going to be jail for him, and I'm sure it will be, I don't want the last memories of our marriage to be about arguing and screaming and all that. Just all the Court case and that. If he goes, I don't want him to be sitting in jail thinking, 'What if she goes off with someone else, because it was all a big quarrel and she doesn't*

*love me no more'. I do not want it to be like that. I need to try to make these last couple of weeks as nice as possible."*

Withdrawal symptoms from opiates are known to include irritability and many women (15: 28) spoke about similar quarrelsome relationships as "you're OK when you've had a hit". Other interviewees commented on the selfishness engendered by a heroin addiction "it ends up they're just out for themselves and you end up falling out all the time". One interviewee described the marital friction generated by having her husband at home all day, following his dismissal as a lorry driver because of his methadone treatment. She attributed some of the blame for their quarrels to the use of methadone rather than the Subutex she now preferred, but this new benefit may have related more to improved relief of the symptoms of withdrawal.

*Michelle, 25 years*

*"In fact he's (husband) just got a job again last week - doing some labouring - to tell you the truth I'm quite relieved. Having him around the house all day was really getting on my nerves. Also I've noticed that since we've been on methadone we've been really bad-tempered with each other - bickering about nothing really. And with not being able to go out, can't afford to do anything. It's been getting me down a bit. I need a bit of space to think - sort my head out. But one thing, I've noticed a big difference with Subutex - we're both on that now and it was like a transformation. It's much easier to talk and more like the old days."*

Some women (5: 28) also reflected on the influences which had initially deterred the development their relationship with a male drug user: amongst these was a dislike of his addict friends, and arguments often ensued. Moira described the period before she first tried heroin, and the way in which her home was inundated by the customers of her drug-dealer husband. She said she had felt under considerable obligation to conform to the group norm of drug use, and that eventually she succumbed to curiosity about the effects she witnessed. She explained that these disagreements ceased when she became absorbed into his drug using circle, and the following extract illustrates her account.

*Moira, 40 years*

*"I must have been about 20 when I started. The reason I got into it was because I used to say, nag at him (husband) 'I don't like all these people coming round to my house, I don't want any of it.' But he started bringing even more of them round, and the more I moaned on about it, he would say to me, 'You're just a killjoy, boring, you won't try anything new'. I did feel under pressure and I didn't want to be the one left out."*

Other interviewees (12: 28) said that their partners' friends soon became their own, thus accelerating the stage of 'apprenticeship' and absorption into the addict lifestyle, which was frequently intensified by the rejection of family and friends (Rosenbaum, 1981a). Kirsty's boyfriend had been jailed for drug-supply offences, and she explained that it was then that she became drawn in to his addict circle, and soon learned to inject heroin. Initially the move to intravenous use was for reasons of economy, since this route of administration provides a more instant and intense effect with less of the substance, and because her drug-dealer partner's supplies were no longer available. In this extract, she explained the role of enhanced membership of the local heroin sub-culture.

*Kirsty, 22 years*

*"I just learned from Tom's (partner) friends. Often, we had a lot of people round to our house, scoring and I'd watched them often enough. They were all his mates, and so they became my friends. I'd lost all my school-friends, they didn't want to know me after I went with him. I was one of them then, even more so."*

Parker and colleagues (1988) have observed that women were more likely than men to become detached from their former social network, mainly since new attachments were formed in series with male addicts. It has also been proposed that because women tend to become absorbed in the heroin lifestyle with their partners more quickly, their isolation from their own social circle increases maladaptive coping mechanisms (Rhoads, 1983).

### **Influence of heroin on consolidating relationships: the 'drug bond'**

Although incidents of domestic abuse were mentioned by several women (13: 28), and frequent arguments by even more (20: 28), interviewees spoke of their addict relationships in positive terms, indicative of a 'drug bond' (Kantor & Strauss, 1989). As an illustration of the 'rapport' which linked them, many women declared that they "could talk to him about anything", and it appeared that this emotional closeness was regarded as emblematic of a strong relationship. One such example was Linda, who was convinced that because she alone knew the details of her husband's childhood abuse, this secret had sealed their union. She elaborated this opinion in the following extract.

*Linda, 23 years*

*"He's (husband) really a very, very quiet person. I mean nobody knows him as anything but violent but I don't know him like that. Ryan (husband) knows himself that nobody will ever know him like I do. The things, the bad things in his*

*life early on, that nobody else in the world knows except me, so nobody ever will know. He wasn't simply a bad lad, he was a bit messed up but he'll always have this reputation of being mad and bad and violent, so he's had to live up to it, put a front on it. And he's trusted me with it and that's what bonds us together."*

However, she went on to note that their relationship had deteriorated since Ryan (husband) had been released from prison. Her voice lowered as she confided this with evident deep disappointment, and she linked his infidelity with a new-found confidence from becoming drug-free.

*Linda, 23 years*

*"Well, we (Linda and husband) haven't been healthy together all the last six years, the heroin, crime, arguments and all the stresses and strains. And probably now I love him (husband) more than he loves me. Well, he sleeps around quite a bit, I know it. (frowns) Devastated, eh. He admitted it when he was in prison, but he's just been a bit more blatant about it since he's been out. He's that cocky with being clean."*

Jamieson (1998) has reviewed the notion that this type of sought-after '*disclosing intimacy*' is central to personal relationships in contemporary society and describes it as an intimacy of the self, one in which the revealing of innermost thoughts is emphasized. However, she challenges the evidence that this idealized relationship is currently widespread, since a true '*intimacy of the self*' would require the dismantling of all structural inequalities, including those of gender. One tenet of Jamieson's (1998) argument is the discrepancy between '*public stories*' and reports of everyday personal lives, and such inconsistencies could be observed in women's accounts of their lived experience of sharing drug use with a partner. Nevertheless, Jamieson (1998) concedes that personal relationships provide a key platform for social interaction and personal development, even if it is unlikely that true equality and '*disclosing intimacy*' are organizing principles in contemporary lives.

This type of '*disclosing intimacy*' was featured within the concept of '*the pure relationship*' theorised by Giddens (1991: 6) who described it as '*one in which external criteria have become dissolved: the relationship exists solely for whatever rewards that the relationship can deliver. In the context of the 'pure relationship', trust can be mobilized only by a process of mutual disclosure*'. However, he asserted that mutual satisfaction is essential for sustainability, since partners would enter into this type of union as equal and independent individuals.

It appeared that for the women in this study, as among the general population (Holland et al, 1998), traditional and hierarchical heterosexual relationships were their preferred choice and lived experience, despite frequent claims of true equality. It may be argued that within a drug-using relationship, heroin provides a strong focus of mutual interest for both partners and when drug use ceases, the lack of this internal criterion can threaten the relationship itself. Indeed, some women (7: 28) shared concerns about the fragility of their addict liaisons, as part of the process of deliberating the costs and benefits of heroin, and this will be discussed in the next sub-section.

**Influence of heroin on relationships: "Is this something else to lose?"**

In considering the impact of heroin on women drug users' relationships, Rosenbaum (1981b) commented on the priority which the drug assumes for addict couples, to the detriment of all other mutual interests. Interviewees often made similar observations (15: 28) and in this extract, Nina interpreted heroin's influence, and then shared her anxieties about the stability of her addict relationship if it became drug-free.

*Nina, 27 years*

*"And another thing I've been thinking of a bit lately, I would just like to know if we'll (Nina and partner) be all right without the drugs in our relationship. Because just lately I've been thinking, the whole thing's drug-related, really. And I would just like to be sure that it'll be OK if we're ever drug-free. But because I can see a change in our attitudes, how we get on, when we have taken drugs to when we haven't scored. You know what I mean, we can just talk better together when we've scored – get on better – we're more relaxed with each other, feel more at ease. You know what I mean. (laughs) When we haven't scored there's more tension and I worry a bit about what it would be like if we were both clean. Is this something else to lose? Talking is the most important thing to keep a relationship together. It's like the heroin keeps us together because of what it does, makes our relationship."*

Those women who were still living with a male addict (10: 28) verified heroin's central role in their relationship, and many women (15: 28) expressed concern that giving up their addiction would mean dissolving their partnership. Nevertheless, some interviewees admitted that it was an issue not yet broached with their boyfriends, and as Elaine remarked *"I haven't found the right time really"*, but in the following extract Nina intimated that it might be beneficial. Kane (1991) has pointed out that avoidance of similar sensitive and potentially threatening issues can often become a strategy for managing the 'status quo' of drug-using relationships.

*Nina, 27 years*

*"I haven't really asked him (partner). Well, I thought that it was a personal decision, really, and he needed to decide that for himself. So no, I haven't really asked him. But I have thought I should because I would like him to try and come off too. It's hard, very, very hard, it's why I'm back on, really."*

One closely-related and prescient concern for some women (15: 28) was the difficulty of adhering to a treatment regime when there was potential, or evident disparity in the desire to commit to shared goals, and issues around treatment will be addressed in a subsequent chapter. It must be noted that similar anxiety about living with a drug-using partner could also be experienced by men who wanted to quit heroin before a wife or girlfriend was equally committed. In the following extract, Gemma explained that the temptation of having access to a partner's supply of heroin was a significant influence.

*Gemma, 27 years*

*"Well, I think the main thing is that it's much harder when you're both using - if one wants to come off and the other doesn't, it's near impossible. If it's right in front of you, you'll just go for it, there's no choice for an addict."*

However, Cindy's account portrayed that an addict couple's relationship could, in certain circumstances, withstand relinquishing heroin. In the next extract, she described how this couple were managing a treatment programme, indicating that having other non-drug-related interests had been significant.

*Cindy, 17 years*

*"It would have been too great a temptation if he'd been still on. It wouldn't have worked otherwise. We're stronger if anything because both of you understand how difficult it is. I mean it was drugs that brought us together and we worked that together but we have other things in common. Out on our bikes all the time, taking the dog for a walk, just ordinary things."*

Nevertheless, most interviewees (22: 28) said that choosing to enter treatment had necessitated a decision to end their relationships with a male drug user. A few of these women (4: 28) explained that, having terminated an addict relationship, they had gone on to develop new liaisons with drug users, and that this had soon resulted in relapse. Attempts to reduce or cease drug use appear to be inhibited by being in an addict relationship (McKeganey & Barnard, 1992; Rhodes & Quirk, 1998), and interviewees agreed that this can create a significant challenge for women drug users. It is quite probable that male drug users would identify a similar effect from being in a relationship with a female

counterpart. Often the decision to part was taken with deep regret, since an enduring attachment was felt to this partner, but there was also acute awareness of the risks of being drawn back to heroin addiction and its associated lifestyle. This is illustrated by the following account.

*Moir, 40 years*

*"We'd (Moir and husband) been together since we were fifteen, and I didn't want to finish with him (husband), but I did. Because there was no way I was doing that again. And I know he's gone back to it, to his old ways, dealing and that. And if I'd gone back to him, that would have been my life, too. I mean, he's done five sentences now, and I thought, he's been through a jail sentence like mine and he's risking doing it again. Not for me: I'm out of it. He was a big influence on me, and I know that. I mean, I did love him."*

Interviewees who had made this choice emphasized the trauma and personal cost of this decision and that it had not been taken lightly, particularly since the immediate outcome was often loneliness and isolation. Jeannie indicated in the next extract the way that 'inundation' into the addict lifestyle had 'narrowed her options' and social circle (Rosenbaum, 1981a), but that she was grateful for her mother's support.

*Jeannie, 23 years*

*"You can't share your life with someone and know they've got something like heroin, it's too big a temptation. I don't have any friends now, really: just my mum. But a lot of people don't have that, help from their family. And you end up, all your friends are users and you're trapped in, any friends that aren't taking don't understand what you're going through. Any boyfriends you might have are inevitably users, so you end up with no-one if you want to stay clean."*

Mutual support between addict partners was viewed with ambivalence since, although it had potential to offer shared commitment to a treatment regime (Pearson, 1987), there could be a greater opportunity for temptation and relapse (Rhodes & Quirk, 1998). A drug-using partner's influence has already been noted to have the potential to undermine efforts towards abstinence (Parkas, 1976; Rhodes & Quirk 1998; Smithberg & Westermeyer, 1985). However, male drug users may have very similar concerns about a female addict partner's influence on continued drug use, and the effect of close association and shared domestic arrangements may be significant.

Furthermore, several women (12: 28) intimated that leaving their drug-using partner was not a short-term solution and that, at least for the foreseeable

future, they intended to remain celibate because the link between heroin and relationships was so closely entwined.

*Jo, 30 years*

*"I've seen it time and time again: one wants to give up and the other doesn't want to. It's just too big a thing to try and leave behind, if the person you're living with is using. If the person is an addict, it's just too much, and sometimes people weigh it up and just choose the relationship. It's a very hard thing. No, I've been on my own since then. When this lifestyle, this kind of drug lifestyle, is over and past, maybe I'll think of a new relationship, but not when I'm like this. I couldn't."*

Rosenbaum, (1981b) has asserted that this enforced celibacy is the ultimate 'narrowed option' for women drug users, which limits their choice to be a girlfriend, partner or wife. She has pointed out that for many women living in disadvantaged circumstances with few opportunities, this may have been one of the few life courses available to them.

Several women (10: 28) did remain with their partners, and nearly half of them indicated (4: 10) that this was often because they could not consider an independent option within their own communities. Borkowski and colleagues (1983) have pointed out that the factors involved can include: the degree of affection and loyalty felt; the value of self-esteem from the relationship itself; and the presence of any alternative resources, particularly financial independence. One interviewee reflected on the value of couples having a chance to explore the basis of their relationships with a skilled counsellor. Pauline provided the following account of a session when she and her husband had attended the drug treatment agency together, but this was the only instance where this was reported.

*Pauline, 39 years*

*"Yes, in fact, Doctor saw us together a little while ago. I thought that was a very good thing. It was good in a way, like marriage guidance (laughs), but it made Johnny (husband) kind of angry - he was very defensive. A bit challenging for him. I don't know why, but sometimes I think the truth hurts with him. He doesn't want to acknowledge his responsibilities himself."*

### **Relationships with non-drug-using partners: "the art of deception"**

In a few instances (5: 30) women had become involved with non-drug-using partners, (although three had previously had addict boyfriends), and the outcome of the disclosure of heroin use could be stressful for both. Carol began

by describing her efforts to sustain paid employment whilst maintaining a heroin lifestyle, and this is depicted in the following extract.

*Carol, 42 years*

*"Yes, I was a dinner lady for 5 years, not while I was with Brian (addict husband) but when my son was at junior school I was a lunchtime organiser. That was quite a strain because I was using all that time and nobody knew at school and I managed to keep it together. You become an expert in the art of deception."*

However, when her second partner, a non-drug-user, discovered that Carol had been injecting drugs throughout the seven years of their relationship, she had to face his anger and hurt at the deception. Carol explained that David was a support worker for the Housing Department, working with many homeless young drug users, but had not observed any indication of his partner's own addiction. Carol said that once practised, duplicity had eventually become routine, but she now had deep regrets about the consequences.

*Carol, 42 years*

*"Easier than you might think really. I used in other people's houses while he was at work. But I remember one difficult time. We were going to Wales for three weeks camping and I had this enormous bottle of methadone to last me, just as a top up. I had it hidden in little bottles in all my clothes. I know it sounds awful but the actual deceit you get that used to it, it becomes easy. He was angry, very hurt, very deceived, and he had been so he was quite right to feel that way. There's no chance of getting back together though that's what I'd like for an outcome in an ideal world. He's said that it's finished. He's kind, thoughtful, I loved him, do love him."*

She went on to explain the complications that ensued soon after, when she discovered her pregnancy, but was surprised and pleased that Dave (former partner) supported her throughout and now has custody of their daughter, as well as her son by a previous marriage. Nevertheless, the strains of living together after the baby was born were evident in this next extract, and she explained the impact on their relationship of suspicion about her heroin use.

*Carol, 42 years*

*"Well, I was five and a half months pregnant before I knew and Dave (non-addict partner) and I had already split up, so I had to find him to tell him he was going to be a father at 52. So we got back together for a short time after she was born, but my drug use was just getting out of control and we split up again. He was more aware of things, noticing what I was doing and pointing it out, so it caused some friction. I was using the same amount when Abby was on the way as with Jason and I managed to reduce it to a level that did them no harm. Dave was not happy*

*but because he knew I had the intelligence to understand the risks and wouldn't want to harm the baby, he went along with it. He knew the doctors were aware of the situation and he was reassured by that. He came to the Ante-natal classes with me even though we were apart at the time. His family don't speak to me because of what I've done to their precious son."*

Another interviewee's partner had to help recover her heroin overdose, and was initially angry about the deception but remained to provide support. In the following extract, Jackie described his response but also explained that this commitment became crucial to her efforts to persevere with treatment.

*Jackie, 22 years*

*"Well, he (non-addict partner) didn't know for about five months because I managed to hide it, but then he went crazy when he found out. I used to hide things away and use when he was out with his mates. But when he'd calmed down, he said he'd help us to come off if I would try. He said he loved us and would stay with us, and now he says he's really proud of us. And I've done it - I've been off for nearly four months now. It was just that my boyfriend was there to encourage me and reassure me that it was all right, and that I'd be able to do it."*

Social support has been identified as 'a key ingredient in both physical and psychological health' (Ussher, 1998: 160) and close supportive relationships are undoubtedly influential in the attempt to achieve abstinence from heroin use. Becky was another interviewee who declared that just having a caring boyfriend and a sense of the future had become a key incentive to become drug-free. However, Martin (boyfriend) strongly disapproved of illicit drug use and was still unaware of Becky's heroin dependence, although they had co-habited for nearly a year. Becky explained the importance of increased self-esteem as a result of her relationship, as well as the significance of new foci of mutual interest and a new non-drug-using social circle.

*Becky, 22 years*

*"Because once you're an addict it's hard to think of friends who aren't. You lose touch with everyone else one way and another. Your world gets very small. But with Martin (non-addict partner), heroin doesn't even come into the conversation. If you've got a roomful of addicts, they might say, right we're having no more from today, but someone is bound to just start talking about it, that's the difference."*

Becky went on to portray the way in which the secrecy had actually increased her heroin use, because urgency to obtain supplies after spending time with her partner had then necessitated independent procurement from local dealers. This

meant that she was able to access heroin more easily and at less cost since she was no longer paying intermediary drug-dealers. She related the way she managed to secure enough heroin and still hide her addiction from Martin (her partner), who she knew would strongly disapprove. Becky went to considerable lengths to avoid discovery as an addict, and seemed to delight in this escapade, as she described her deception in the following extract.

*Becky, 22 years*

*"Oh no, he (partner) doesn't know. His brother smokes a little bit of pot, and he won't even let him use it in the house. Mind you, I think he thought it was a bit strange, because I took a lot of baths. I got up in the morning, well, to explain the set up of the house, it was perfect. There was a parlour and a kitchen and then the bathroom right at the back, lock on the door, a long sort of house. He'd say, 'You take ages in there - what have you been doing?' (laughs) but he couldn't smell it or anything because I had all my bubble baths and lotions and shampoos and stuff. Morning and night I found a way I could do it. I had a little metal pencil case with all my stuff in it, and I'd hide it in the back of my bag (laughs)."*

More frequently (6: 28) women told of former non-drug-using partners being totally unaccommodating of the discovery of heroin use, and often spoke of their instant rejection: Lisa claimed that her frustration and irritation with one mistrustful boyfriend, who suspected that she might still be using heroin, was in fact the trigger for relapse. She explained the context in the following extract.

*Lisa, 23 years*

*"Yes, I did once (have a non-using boyfriend), for a while when I'd managed to get off it for a little while, but once he (partner) found out that I had been a user, he kept accusing me of being back on it, and I wasn't. That really made me fed up, paranoid, he was. It really got my back up, and I really think that put me back on it in a way. We didn't last very long together. I thought I was trying so hard, and if he thinks that much that I'm back on it, I might as well be, so I did."*

## **Summary**

This section has reviewed the complex interplay which was portrayed between heroin and sexual relationships, and the way in which addiction appeared to influence and be influenced in symbiosis. The majority of interviewees had used heroin with a partner and accounted for the drug's initially positive effects on their relationships, inducing relaxation and providing commonality. However, these benefits were soon outbalanced by adverse consequences such as: the exclusive focus of interest; impeded sexual communication; sometimes control

and abuse; duplicity and loss of trust; constant quarrels; ambivalence about treatment and for many of the women, the sequelae of celibacy and loneliness.

Interviewees confirmed the potency of this '*site of risk management*' (Rhodes & Quirk, 1998) by claiming that drug use with a partner had influenced the equalization of heroin consumption; altered perceptions of any risks involved, due to the meanings, customs and practices of intimacy; and often constrained attempts toward abstinence. It is quite possible that male drug users might observe that their addiction increased when in a relationship with a more experienced female drug user. Indeed, three interviewees expressed some guilt that they had influenced a partner to increase his heroin use, or even to initiate his injecting drug use. This equalizing effect may therefore be more concerned with the impact of close association rather than any gendered aspects of their relationship. However, it may be surmised that for women drug users, the greater proportion of whom have addict partners (Davies, *et al*, 1996; Gossop *et al*, 1994; McKeganey & Barnard, 1992), having regular access to a readily available supply of their partner's heroin, particularly if he was a dealer, could create an environment where dependence might flourish.

Despite descriptions of the risks and influences of relationships, interviewees refused to blame their partners for their problem drug use and asserted their own agency. Nevertheless, some interviewees believed that once their own drug use had become problematic, this dependence had been exploited by partners as a means of abusing power and controlling her access to heroin. The women's lived experience of using heroin with a partner highlighted the constant interactions between risk and behaviour, which seemed to be managed on an everyday basis. Interviewees consistently described a qualitative distinction between the influences of partners and of friends upon their problem drug use, linking the former with a peculiar trust: the next section will account for what the women said about friendship relationships.

### **Relationships with Friends: Influences and risks**

Relationships with friends were recognized to have been influential on the women's pattern of drug use, and all of the interviewees mentioned an elevation of addiction because of the nature of group activity. Tajfel (1978) has argued

that that the salience of group membership depends on its contribution to an individual's identity and it has been argued that many young people may use substances to define or enhance social status (Beckett *et al*, 2004; Measham, 2002). Indeed, many women claimed drug use had been a positive part of their social lives and the initially pleasurable effects were often classed as '*some of the rewards*' (Davis, 1994) of a drug-using lifestyle. The association between drug-taking and peer relationships was portrayed by interviewees as strong, and as an accepted part of youth recreation (Parker *et al*, 1998; Rosenbaum, 1981a; Wister & Avison, 1982): trying '*dance drugs*' had often been an initiation into substance use as well as a means of defining their femininity (Measham, 2002). Most of the women (22: 28) had met their sexual partners as part of that group of friends, and sometimes (8: 28) it was revealed that he was the dealer who supplied heroin to that social network. Conversely, a few women (6: 30) attributed their heroin use to loneliness and to their efforts to gain popularity or acceptance. However, Elaine portrayed the complexity of heroin addiction and also alluded to an affective component.

*Elaine, 24 years*

*"Just this love affair with heroin that I have - that's what keeps you using. It's tied up with so many things, your boyfriend, your mates. It took me such a long time to admit I had a problem with heroin, and even longer to decide to do something about it."*

This section will account for interviewees' reflections on the particular importance of friendships in the course of their dependence: a few (6: 30) claimed that a lack of friends had been a factor in initiation. However, the majority (20: 30) mentioned the social isolation of extricating themselves from former drug-using contacts, as a first step towards ceasing heroin use. Several women (13: 30) highlighted the obligations and responsibilities attached to being a member of an addict social circle.

In their narratives, many (18: 30) women differentiated between their experiences of companionship, such as "*non-using friends*" and "*drug-using associates*", and stressed the importance of this. Elaine went on to share her anxieties about meeting the former group when intoxicated with heroin, and the potential for thus jeopardizing her reputation.

*Elaine, 24 years*

*"I have a few non-using friends, just mine, not Alex's (partner). I try to keep up with them. There aren't very many, but I feel guilty, or is it more ashamed, that they might see me when I've been using heroin. Because it changes you, doesn't it, and then they'd know. The way it is with proper friends, maybe they're not there for you when you're into taking heroin, but if I really wanted help, and I was trying, they would be there. Whereas the people you just associate with, hanging around, day to day sort of thing, gear and all that, they're not friends. Just people you use to get what you want. They are two different groups."*

All of the women lamented lost friendships as a consequence of the disclosure of heroin use, and this was one aspect of becoming a drug user which was clearly deeply regretted. Jan's comments are typical of many of the women interviewed.

*Jan, 30 years*

*"I had friends, good friends and I lost them with the drugs. Now I'm finished with the drugs though, some of them are ringing me again. I don't see the drug users no more, I've left them behind. I really haven't had a proper social life since before the drugs come along - five years - and really I don't know how to start now."*

### **Influence of a drug-using social milieu**

A few women (6: 30) believed that friendship relationships could develop to some extent and that other drug users could provide support in terms of reliable advice and the sharing of drugs, equipment or money. It appeared that this mutual support was perceived as emblematic of a type of bonding and trust. As dependence and 'inundation' deepened, many women became estranged from their families and the relationship with drug-using partners and social contacts became increasingly important. In this extract, Fiona explained that she began to use heroin with her boyfriend in a social circle where heroin use was commonplace. However, after he was jailed, a girlfriend initiated her into injecting and as an experienced drug-using peer, who seemed to have suffered no ill-effects, she felt confident of this advice. A contributory factor was the need to economise on heroin by using it intravenously, since Fiona's source of supply had been seriously affected by her dealer boyfriend's incarceration.

*Fiona, 24 years*

*"At that time, just associates, not friends. When I started first of all, I had no friends who were drug users, but I knew people who did. When I started they were, so I was very familiar with it. That was the difference, you'd seen it being done, what the effect was and you could weigh it up for yourself. A friend talked us into it. I was quite scared, but I was persuaded. She said it would help to use*

less, help with the withdrawals. Lots of people I knew were injecting and seemed to manage so I thought I might as well."

### **Influence of social obligations**

It was also conveyed by several interviewees (13: 30) that drug user relationships carried obligations in certain circumstances, such as if an individual had money or heroin to share and the rest of the group did not, or to provide assistance in the case of overdose. Sharon explained that friendship ties were complicating her progress in treatment, since her drug-user duties were still powerful and unresolved. Living in communities where drug use was commonplace meant that this was an ever-present risk to effective treatment for some interviewees.

*Sharon, 22 years*

*"My big problem is going to see my mates. In ten minutes somebody is putting a bag in my hand. I need to find a new circle of friends, but it's so hard. I mean, these are my mates: I've known them all my life, nearly. We've done loads of things together, and I love them to bits. But I can't keep putting up with it. I've said to them, please don't do it in front of me, I'm doing my rattle here. But you can guarantee that's just what they'll do, and in a way I end up paying for their habits, too. When I first started, I ended up buying heroin for them too, because I had a job. While I'm still dabbling in heroin they know how to reel me in."*

As well as attending to the withdrawal needs of other heroin users, several women (13: 30) also described their fears about, but also the duty to assist with an overdose crisis. They often spoke of the dilemma of whether to risk calling emergency services, since the potential for police accompaniment became a deterrent. In this extract, Lara illustrated a typical situation.

*Lara, 28 years*

*"I would be glad to help anybody else in that situation, for example I couldn't stop helping this lad with an overdose, someone I used to know. I was in the street at the time, and they couldn't get him in the ambulance, and all his mates were threatening me for getting it, because they thought the police would come next. And the ambulance girl said 'Thanks lass, we couldn't have done it without your help.' Next week, he came and thanked me for saving his life, and said he was sorry they'd had a go at me. I'd always help someone in trouble."*

On the other hand, as an example of the complexity of addict relationships, there were many (16: 30) tales of the selfishness and unreliability of other drug-users, although it was proposed that this might often relate to the demands of heroin withdrawal rather than personal characteristics. In this next extract, Cindy

provided an instance of the level of ruthlessness which she said was pervasive amongst addict associates.

*Cindy, 17 years*

*"Other people used to cling on. Well, every smackhead does it, we (Cindy and partner) did it ourselves. Hang around somebody that's got a lot, saying you need sorted out, need your rattle sorted out. They won't see you like that - it's a thing with drug-users. But a little's not enough, you want the lot, so you end up robbing them of their stash. Ripping people off all the time."*

It was clarified that this lack of trust was an important distinction between using drugs with peers and with sexual partners. Interviewees explained that trust, whilst central to a dyadic relationship, was less crucial amongst drug-using associates, and Taylor (1993) remarked that although women addicts were mutually supportive of each other, trust was not a feature.

As an indication of the powerful influence of the social milieu of drug use, some women (9: 30) explained that other drug users were unsympathetic and unhelpful to them when they first attempted to reduce consumption. This proposed behaviour change seemed to be unsettling for peers when heroin had been consumed as a group activity. Nevertheless, in this extract Cheryl spoke with sadness of the trauma of parting from her companions and the resulting social isolation.

*Cheryl, 23 years*

*"I was just knocking around with the same group of girls, and it was too hard if they were still on it. Breaking away from the circle that you're in is the very hardest thing. Leaving your mates, and all that means to you. Everyone knows everyone else round here, and there's a lot of stigma with being a user. People know about what you've done, and people that don't use, they don't want to have anything to do with you. So you have to shut yourself away, really."*

### **Influence of loneliness and exclusion from peer groups**

As a further illustration of the importance of social relationships, a few women (6: 30) explained the long-term impact of being friendless and attributed this to various aspects of *"being different"*. Fiona explained that she had experienced systematic bullying about her perceived sexual orientation in early adolescence, and she believed that this had resulted in loneliness and low self-esteem.

*Fiona, 24 years*

*"Because I was like a tomboy and get picked on, called names. My dad's got his own garage, so I was brought up playing around the garage and that. I was right into bikes and cars more than Barbie dolls. I was a right tomboy, and people thought that I was a queer. When I went to school I was got at all the time, bullied, but when I got to about 14, I stopped putting up with it and I kind of exploded, fighting and that, and I ended up getting expelled. I was sent to the centre for bad behaviour children. I got really depressed. But the heroin seemed to take away quite a lot of my problems for a while."*

Interviewees (5: 30) who had experienced similar intense loneliness claimed that lack of company as well as adolescent depression and truanting, had even predisposed and contributed to their drug dependence. Another interviewee was certain that her isolation was due to obesity: she claimed that she had always been ridiculed at school, and until very recently had never had a boyfriend. It has been claimed that young women may be more vulnerable to the social stigma attached to obesity (McIntyre, 1998), which is now more common among lower socio-economic groups (DH, 1999c). Serious weight problems can result in young women being perceived by peers as being: passive; unhealthy; or weak-willed; and having inferior physical abilities (McIntyre, 1998). Other psychosocial sequelae can include low self-esteem, rejection and shame, which it has been asserted is greater and more enduring for young women than young men (Hill & Williams, 1998; Brown *et al*, 2000). Here, Becky explained how this factor had increased her vulnerability to substance misuse.

*Becky, 22 years*

*"I never thought I was ruining my life because, as far as I was concerned, I didn't have a life to ruin. I was a size 26, and was bullied all the time I was at school. My downfall was with not being popular, I tried to be by going along with it all and joining the crowd. If I had money and they had a habit, I became their best friend, know what I mean? It's hard not to join in. It's been just the same for drink, and for smoking."*

Becky believed that being socially excluded by her appearance had affected her confidence, and had also made her vulnerable to manipulation by drug-using associates. By way of illustration, she went on to describe a situation of financial bullying over the purchase of a car which she felt unable to report to the police, because of the links with illegal drug users.

Some women (6: 30) had suffered bereavement of close relatives, but Sharon also described the void left by the death of her best friend. In the next extract, she

accounted for an enduring loneliness since many peers had already left school for a range of reasons, including teenage pregnancy.

*Sharon, 22 years*

*"All my friends had left, more than half of them had got pregnant and had to leave. I just didn't want to be there on my own. I had a best mate at school, but her family went to Australia. She came back a couple of years ago, but she was out in a car with her boyfriend and got killed in the back roads. I couldn't cope with that: I was devastated. Two years ago, come 28<sup>th</sup> November. I used to drink with her. When we were 12 - we drank cider in the park, had a laugh together. But she wouldn't have used heroin, she had more sense and I really miss her."*

The widely-accepted guidance from treatment agencies to separate from former drug-using associates had been accepted by all as an essential part of their regime. Nevertheless, interviewees said it was distressing and a sense of social isolation was strongly felt, particularly when they lived in communities where drug use was prevalent. Most women (25: 30) explained that everyone they had known was a drug user and that there was nothing they could do which didn't draw them close to heroin. Becky found that she had a particular dilemma when former addict associates expected her to condone their shoplifting, but she was aware of the long-term impact on her financial independence and chances of recovery from addiction, if she allowed this to continue. Becky said that her own honesty separated her from the majority of addicts and she perceived herself as distinct in this aspect: she explained that by earning and borrowing money she had maintained her heroin addiction.

*Becky, 22 years*

*"In a way, I know it's a bad thing to say, even to think, but I don't see myself in the same class as a lot of these addicts. I've never stole off anyone to buy heroin, and most of them have. There was always someone to lend us something if I was short, and I've never lied to anyone, always paid my debts. It can be very hard at work sometimes, because these thieving types, they know me, and they expect me to turn a blind eye if they come in with their carrier bags to nick jars of coffee and bottles of drink to sell on. They know I'm on the till, but I pull them over and say, 'Just stop it - put it back or I'm phoning the police. I'm not risking my job for you lot'. It's my independence. I don't have to ask my dad for money - it's the way to get a normal life back."*

Some women (6: 30) had been imprisoned for drug-related offences, and half of them (3: 6) mentioned that release from prison could also increase social isolation, if they wanted to avoid recidivism. It has been pointed out that it can be difficult for some offenders to return to the small communities in which they

had grown up and to establish new social networks, because it can be particularly difficult to dispel criminal reputations in non-urban settings (Howard League, 2006; Meek, 2006). As a younger woman, Moira had served a custodial sentence for assisting her husband's drug dealing, and she reflected on the problems she had experienced on release at that time. She said that she had been determined to avoid all contact with her former drug-using network and had tried to make new friends, but eventually the difficulties of doing so drew her back to heroin. In this extract, Moira recollected her embarrassment in that situation, and also shared a view that young people might be more fearful of being judged and could require greater support.

*Moira, 40 years*

*"But then I found it so hard to make new friends. New people I didn't feel I had anything in common with. I went and had a coffee with some eventually, the old friends, because it seemed they were the only ones I could relate to, and that was my downfall. I met a new lad one time, and I felt so ashamed, I couldn't tell him about my past. And I had to let him go. Now I'm different. I think I can let people judge me if they want. Some folk judge you right away, soon as they know."*

Moira went on to paraphrase the key points inherent in Ussher's (1998) assertion that individuals need to have the company and support of friends, and in this extract she makes it clear that recovering addicts are no different from the rest of the population.

*Moira, 40 years*

*"You've got to change the lot, lifestyle, friends, everything. If you don't you'll never move on. Your own willpower's got to do it, but if you need help its help to build your life together again. Some purpose to your life, friends to have a laugh. If you can't feel good about yourself, that not everyone despises you, you'll never move on."*

## **Summary**

This section has reviewed the influences of friendship ties on women's drug use and the meanings that interviewees attached to such relationships. Early drug-trying had often derived from a desire to comply with the expectations of peers, and was said to have become a shared group activity in a recreational context. None of the women implied that she had ever been coerced into problem drug use by this group of friends, and interviewees consistently accepted responsibility for that decision. Nevertheless, there were obligations attached to

drug use with friends, and in a crisis, the duty to assist with withdrawal symptoms or overdose was widely recognized.

Women frequently made a distinction between "*non-using true friends*" and "*drug-using associates*", who could never entirely be trusted. Issues relating to the quality of trust were said to differentiate drug use with their social circle from the unique and superior relationship with sexual partners that many women (23: 28) described. Interviewees consistently commented (23: 28) that it was actually when they began to use with a partner that they "*really got into it.*" It was again conveyed that the intensity, commitment and closeness of the sexual relationship mirrored the development of dependence. However, interviewees (5: 26) sometimes described sharing injecting equipment with very close friends, and said that this was symbolic of a special '*rapport*', where any potential risk was regarded as of secondary importance.

The next chapter will begin by focussing on the influences of other personal relationships, and will account for that with parents, siblings and wider kin. The second half of the chapter will then describe what the women who were mothers said about the impact of their heroin addiction upon their own children, and their claims of the influence of their children upon their addiction.

These additional influences develop the descriptive account of the spectrum of factors which was said to have affected interviewees' addiction. Throughout their narratives, interviewees described these factors as influential but either predisposing or contributory, and women were keen to clarify that they themselves bore responsibility for becoming involved in problem drug use.

## **Chapter 5**

### **Relationships: Influences and Risks Families and Children**

This chapter will now investigate both the women's accounts of the influence of family relationships on their drug use, and the effect of their heroin addiction upon their family of origin. It will consider the impact of family dynamics and interviewees' reports of how this was sometimes mediated by parental substance misuse or some form of victimization. In some instances, it appeared that siblings could have influenced initiation, but in others non-drug-using siblings were deeply ashamed and rejected their addict sister. The effect on families themselves appeared to be differentiated by position within this group, but disclosure or discovery of drug use was said to be always traumatic, and evoked a range of responses. There were portrayals of the grief, despair and enduring stress experienced by parents, as well as by many siblings and other kin. It was often said that these reactions were tempered by gendered expectations of a daughter, granddaughter or sister (Ettorre, 1992). Disclosure could bring the risk of estrangement from the family, but several interviewees spoke with gratitude of the support that their relatives had provided.

This chapter will then continue to include accounts of the women's relationships with their own children: more than half of interviewees were mothers, although some were not living with their children. It will describe interviewees' perceptions of the impact of a mother's heroin addiction, as well as the powerful catalyst children were claimed to have exerted on her motivation to cease drug use. The risk of losing custody of their children was portrayed as an omnipresent threat for drug-using women, and was said to have influenced any thoughts of seeking help. In this study, the main focus was upon influences on the women themselves, rather than the situation for their children. Since contact with interviewees was temporary and their children were only occasionally present, an objective assessment of the children's well-being was

not possible. Impressions therefore relied on their mother's views and the satisfactory opinions of those individuals who had sponsored the interview.

### **Influence of family relationships upon interviewees' drug use**

It has often been asserted that the dynamics of drug-users' childhood domestic circumstances might, at least in part, be at the root of the heroin addiction (Copello & Orford, 2002). In this study, many women explained that disturbed family dynamics were a predisposing influence rather than the cause of their addiction, and they retained full ownership of the decision to become involved in problem drug use. Nevertheless, home circumstances were mentioned by many (20: 30) of the women in this study, either to deny its effect (5: 30) or, more frequently (15: 30) to describe family dysfunction. Kitty's response and summary assessment of her background in the following extract was typical of many interviewees.

*Kitty, 26 years*

*"My family, you don't want to know. They're worse than me. (laughs). My mum's died and my dad's remarried but I have nothing to do with them. And my sister, she's in Court today. Her husband's doing five years, same charges as him, Supply."*

Women explained that dysfunctional circumstances might include either parental substance misuse or the occurrence of physical, emotional or sexual abuse. Pauline was one interviewee who recalled her childhood experiences, and she described in detail the effect of early separation from her mother; her father's alcoholism; and the regular violent abuse which resulted in her removal to a constantly-changing range of care environments.

Allen (2003) has pointed out that there can be increased disadvantage for young people in care in similar non-urban locations, since there can be a greater lack of suitable accommodation, and that this is often compounded by poor social networks, transport and financial difficulties. However, this experience of being 'looked after' is likely to affect young people in any setting with precipitating events such as: bereavement; rejection; domestic abuse; early independence and responsibility; or sex work having an important influence (Ward *et al*, 2003). It has already been established that 'looked after' young people report higher levels of problem drug use, use drugs more frequently and begin at an earlier age (Newburn & Pearson, 2002; Ward, 1998; Ward *et al*, 2003). Many such young

people report drug use as one of many problem areas in their lives (Ward *et al*, 2003). In the following extract, Pauline describes her recollections of early family life in detail and pronounced its enduring impact upon herself and her siblings.

*Pauline, 39 years*

*"Well, my mum left us when we were little. I've met her a couple of times in my life since. She lives near, but I'm not in contact with her. We don't have a relationship. My father was an alcoholic, and very violent. I'll never know why she left us. Was he violent to her as well as us? I did want to say to her, 'Why did you leave four little children?' because I couldn't do it. I've still got a lot of anger about that, but you've just got to get on with it, haven't you? I don't understand why she never came back, never came to see us or got in touch. Just went. I can't even remember mum being there, so I was quite small. I went to a sort of special boarding school, for a few years. Foster parents of all sorts, all over the place. We were all split up, too, and that was hard. One place to the next. In a way, it was good to get away, get away from the violence and my dad beating us all up. But in the Home it was hard to get to tell people what was going on. In them days, they weren't as good with doing that. We should have been taken away a lot younger. I don't know how he managed to keep us as long as he did. I had my little sister to worry about. My brother left at 14 and went into a world of his own - we don't hear from him. But the three girls have all ended up on drugs, I lost my younger sister with drugs, she overdosed and died. My older sister still is, and I think she'll kill herself too. I don't really know why I take it myself, because I get nothing off it when I do take it. I get that low, that depressed, I think I'll just have a go."*

A few other interviewees (5: 30) accounted for the impact of living with alcohol-dependent parents but only one woman had grown up with heroin users. In particular, the experience of witnessing alcohol-related violence from an early age was said to have had a profound impact, as Jo explained in the next extract. She also shared feelings of shame that her own addictive behaviour was exposing another generation, her own children, to harm.

*Jo, 30 years*

*"I mean, when I was growing up, my father was an alcoholic, and he was constantly violent to my mother. They're separated now, but as a child it was so frightening, you didn't know what would happen next. It's probably had quite a bit to do with my drug use. Not a nice thing for children. I always said my kids would never live through things like that until suddenly it was happening to their mother too."*

Jo went on to account for other aspects of family life: in particular that her older brother, a drug dealer who had initiated her own heroin use, had recently been disowned and excluded from the family on account of his ruthless behaviour.

Jo, 30 years

*"They've washed their hands of my brother now – he's in jail anyway. He actually got my mother sent to jail for 12 months – sent her on a run with a load of heroin because he knew the police were watching him."*

Another interviewee, as a daughter of heroin addicts, explained that addiction had devastated and disrupted her early years. Jeannie's parents had begun lengthy prison sentences for drugs supply when she was aged three, and she was raised by grandparents. Her mother divorced on release from prison, while her father continued to deal heroin and had now served five further sentences. Despite this, Jeannie commented that this background had not served as a deterrent to her own drug-trying and eventual dependence, and she maintained her own agency in this choice.

Jeannie, 23 years

*"I mean my parents were addicts and I knew what happened with them so I was scared of what might be ahead of me. But I suppose you always think you might be different, not get dragged down the same."*

On the other hand, a few women (5: 30) were keen to explain that they were from "a good family" and had a "proper family life", and denied this influence in their own circumstances. Gemma was one who said that she had a sound family background, but when she went on to describe family life in more detail it became clear that it was not entirely harmonious. Her description of her father's personality made it apparent that the home environment probably hosted tensions.

Gemma, 27 years

*"They separated three or four years ago, and he has a new partner now. He's a bit of a grump, really. If there was any family discussion or disagreement, he would hang on to his position, and would just argue and argue. We're a bit alike like that. He's got a good job at the plant and always thought a lot about his work. That and drinking with his mates. Dad gets really worked up about things but he's not violent in the house really."*

### **Influence of siblings on interviewees' drug use**

Several interviewees (10: 30) claimed that they had been affected by the substance misuse of older siblings, and Barnard (2005) has proposed the influence of role modelling, as well as increased proximity to substances. She argues that the familial relationship may legitimate experimentation and even

reduce the threat of danger, and has noted that some older siblings may try to compromise younger brothers or sisters to ensure cooperation in maintaining secrecy. Lara was one interviewee who spoke of similar experiences, and in this extract she also explained the influence of being the youngest in a family where drug use had become normalised, and of engaging with her older brothers' activities.

*Lara, 28 years*

*"I've got a bad background, you see, it's all in my family. There are four of us, and three of us have been heroin addicts. My two brothers still are. They used to pinch, and I was the youngest in the family so I used to get it all look out on us. My sister would never have anything to do with us. I used to go round with the boys and depended on my brothers, a bit of a tomboy. So I think the drugs, that was it, too – in with the lads. I remember catching my brother smoking cannabis in my mother's house, and so they made me smoke it too, so I didn't grass on them." (laughs).*

Lara explained that in this family position she often suffered punishment for her older brothers' misdeeds and that culpability for their actions persists. This retribution could often amount to serious physical assaults and injury, in revenge for her brothers' criminality, and she resented taking this blame.

Several other interviewees (10: 30) said they had siblings who were involved in substance misuse and this pattern has been noted elsewhere (Bahr *et al*, 2003; Bancroft *et al*, 2004; Barnard, 2005; Boyd & Guthrie, 1996; Luthar *et al*, 1993). Despite a shared family history, there were a few examples of brothers and sisters who had resisted drug use and whose lives had taken a different direction. Barnard (2005) has pointed out this disparity, and suggests that resistance to drug use may be linked with a commitment to conventional social values and the choice of different, non-drug-using friendship networks. Bahr and colleagues (2003) confirm that the influences are complex, and that resistance to initiation is not entirely related to whether there are opportunities to try drugs. Liz's account provides an example of this variation in behaviour between sisters and she described the enduring animosity about substance misuse which prevailed between the sisters.

*Liz, 21 years*

*"My sister's older than me and has always been my parents' perfect child. We don't have anything to do with each other – she's ashamed of me. She's absolutely minted, married someone who owns a bus company and they've got a*

*swimming pool and everything. My parents wanted me to be the same and I always disappointed them – couldn't live up to her. We've never got on that well but I don't blame her for how she sees me. I'd like her to understand one day."*

### **Influence of childhood victimisation on interviewees' drug use**

In addition to the negative impact of parental or sibling substance misuse, some commentators have identified childhood victimization, including sexual abuse, as a precursor to young people's problematic drug use (Fergusson & Lynskey, 1997; Kendler *et al*, 2000; Marcenko *et al*, 2000; McKeganey *et al*, 2005; Paone *et al*, 1992; Stewart *et al*, 1998). Vogt (1998) had identified that experience of violence, particularly if sexual, is a significant underlying factor for substance misuse, and that as many as 70% of women in contact with treatment services are said to be survivors of sexual or other assault (Roth, 1991; Russell & Wilsnack, 1991; Wilson, 1997). Some interviewees (8: 30) indicated that family malaise had included physical or sexual abuse by trusted individuals, and that this was still traumatic. Since this type of victimisation often presents among drug users approaching treatment agencies, it has been asserted that staff must be able to respond effectively with appropriate support (McKeganey *et al*, 2005). The following extract illustrates an example of the type of abuse which some women (8: 30) believed had predisposed their problem drug use, although they retained ownership of initiation and the decision to continue its use.

*Linda, 23 years*

*"Well I don't really like to talk about it much but my mam had a guest house and I got abused when I was only little by some of her lodgers, she knew about it – it was a nightmare and I live with it. I think that stopped me getting on as well as I could have at school you know. I feel like I was doomed from the day I was born. All my life, all my life." (head in hands)*

Sara recalled the influence of beatings by her father, resulting in her subsequent removal into Local Authority care where she began drug-taking. The following extract provides an example of her comments on the context of his aggression and the discordant and stressful atmosphere within the family.

*Sara, 26 years*

*"But life's just a disappointment for him (father). He's an upstanding member of the community. Nobody believed me that he hit me. I was in the home three weeks and Dad said he was sorry and I should come home. It lasted 18 days, and he hit me again, and that was it. My mother's not an outgoing person, very introverted, very bitter about the MS and everything else. They were going to get divorced when I was nine, but then my Mum got MS. My Dad said, 'if I leave her*

*now, I'm a sonofabitch, and if I stay it will be hell'. She's just so angry and so bitter and so is he."*

In summary, it was revealed that many young lives had been affected by various facets of disturbed family dynamics, and that this may have been a predisposing factor for subsequent problematic drug use. Whilst dysfunction within their families of origin was described in several narratives, interviewees said they regarded this as only a contributory factor, and maintained that the decision to use heroin had been their own. In addition to this background influence of family relationships on the women's drug use, there were many references to addiction's own pernicious effect upon their kith and kin and this will be considered in the next section.

### **Influence of interviewees' heroin use upon family relationships**

It has been established that problematic drug use can impact on families in diverse ways, which are not mutually exclusive, and these can include: physical and psychological health; financial insecurity; and consequences for social life in the wider community (Bancroft *et al*, 2002). Frequently, these effects will be associated with stress, depression and an increased incidence of domestic violence (Bancroft *et al*, 2002). Drug use can disrupt family life, frequently destroying expectations for the future, and it has been asserted that mothers in particular may suffer because there is often a great deal of personal investment in maternal relationships (Donoghoe *et al*, 1987; Dorn *et al*, 1987). It was often intimated that interviewees were painfully aware of the impact that their drug use had exerted upon these personal relationships. Velleman and colleagues (1993) have indicated that the concerns which are most frequently present for families focus upon the addict's deception, manipulation and self-neglect.

### **Influences of interviewees' drug use on the health of relatives**

A few (3: 30) interviewees spoke of the overwhelming despair and suicidal intent of those relatives who were unable to cope with the stigma and self-blame attached to being the parent of an illicit drug user. In this extract, Sue describes an example of the enduring stress and tension experienced by close relatives faced with problem drug use in the family.

*Sue, 32 years*

*"All three of us on drugs. My mam has tried to commit suicide three times because she thought it was all her fault. All of her children addicts. Blames herself, but I've tried to explain, it's not her fault. Though at one time I did blame her. You know what I mean, not being there for me when I needed her. And really, she was there, it was just me, the stage I was at, the state I was in, I just couldn't see it. I mean, that time, those years I was working on the streets, she was paranoid, terrified she'd get a knock on the door - the police, and she'd have to identify me."*

It became evident that women were not oblivious to the impact of their addiction on relatives, and they claimed to be assailed by deep guilt and feelings of failure when for example, the death of a parent could be linked with their drug problem. Jan comforted herself with the belief that her father could at least see some improvement in her appearance before he died, but revealed that her sister retained the view that Jan's drug use had been a significant influence.

*Jan, 30 years*

*"My mam, brilliant. Upset like, but she's stood by me. My Dad though was very, very upset and didn't want to talk to us. I was his baby and he just couldn't believe I'd lowered myself like this. I come from a good family. I was just pleased I'd got off before he died last October. He could see me getting back to normal and didn't go out thinking he had a dirty, scruffy junkie daughter. I couldn't be bothered to wash my hair, take a bath, nothing. I have a sister but we don't get on, don't talk now, because of the drugs. She thinks that I finished my dad, it was running my whole life."*

### **Influence of interviewees' drug use upon non-drug-using siblings**

The impact on families often seemed to be differentiated by family position, and several women (14: 30) spoke of non-drug-using siblings who were said to have been deeply ashamed, rejecting the sister who had brought their family disgrace. It was pointed out that siblings often had overlapping social networks with their addict sister. Interviewees frequently suggested that the 'high level of social communication' (Scottish Drugs Forum, 1997) in the local area meant that reputations were rapidly disseminated (Henderson, 1998; Jamieson, 1998; Scottish Drugs Forum, 1997). Nevertheless, it must be acknowledged that similar experiences could also be evident in inner-city communities.

Animosity could rapidly develop between siblings, and it was often reported that reconciliation had still not taken place. Barnard (2005) has commented that the concerns of siblings often focus on the effects on their parents, although these brothers and sisters themselves could suffer from the diversion of family

attention and resources. Several interviewees (14: 30) confided that many non-drug-using siblings deeply resented any adverse consequences for parents, and parental ill health and even premature death were blamed on the addicted sister. This could often lead to total estrangement from the family unit, and increasing isolation could deepen interviewees' 'inundation', and further engagement in addict networks.

### **The effects of disclosure of interviewees' heroin use to relatives**

The effects of disclosure, or the discovery of interviewees' heroin use by close relatives were described with deep remorse by many women (18: 30). In this extract, Jo said she had now repented and fully appreciated her family's support.

*Jo, 30 years*

*"I regret most of all the relationship I had with my family and what it did to that, they distanced themselves. When you fall out with your family and have no contact with them for a while, then you start to think what you've done, hurt them so much. I've put them all through a lot. They tried to help but you end up going back to it and back to it again and again. They can only give you so many chances, and I've used mine up, just about. I'm lucky at the moment, I'm getting on well with my dad. I'm very, very, very lucky that my parents have stood by me."*

Parents reacted in different ways to the news that their daughter was a heroin addict: this seemed to vary both by gender and in terms of coping strategies. Orford and colleagues (1992) suggest that the most effective coping styles are confrontation and offering support for the user. A number of interviewees (14: 30) described incidents of confrontation with anecdotes of "they went mental" and "she went absolutely ballistic", as well as portrayals of the disappointment and despair experienced by parents and other relatives. On the other hand, Becky was surprised by her mother's response, but recalled her dilemma about revealing her addiction. Marshall (1993) has asserted that mothers often try to conceal their child's drug use from fathers, but the following extract described the only instance where this was reported.

*Becky, 22 years*

*"The hardest is, you need support but it's hard to tell people and guess how they will react. It's the telling people that's the big risk. I didn't know how my mum would react when I went to see the doctor that time. I came home and I didn't know she'd took a day off work sick, and I burst in the house crying. She knew I'd had an appointment, problems with my back, I'd said. And we were both crying, her arms round me and that. And I explained, and she said, "Is that it? Is*

*that all it is? I thought you'd had an abortion or something. You can't undo an abortion, but you can get through this. What kind of mother would I be if I couldn't help you?' But my sister, I think she might tell everybody, and my dad would kick right off. I'd just be proving my dad right, and I can't do that."*

It has been suggested that drug use by daughters can be particularly difficult for parents to accommodate (Ettorre, 1992; Raine, 2001), and interviewees accounted for reactions of shock and loss which were said to have been more intense than those accorded to drug-using brothers. Anxiety about the welfare of their daughter was said to have provoked over-vigilance in some cases (4: 30), and additional tensions could emerge when young women perceived their independence to be threatened. Sometimes this was because of their gaunt, heroin-wasted appearance and the women themselves were often distressed by their body image (Ettorre, 2004, Taylor, 1993). However, Gillie's mother was more concerned about her social life and this was already causing quarrels.

*Gillie, 20 years*

*"She's (mother) always on at me - thinks I'm going back on heroin if I step outside the house. I mean, I can't stay in all the time can I? Twenty year old - I need to do what twenty year olds do don't I?"*

Some (6: 30) women had been brought up, or mainly cared for, by grandparents, and they felt particular sorrow for the distress and shame caused to these relatives, who may be less familiar with the phenomenon of heroin use, and less well supported, when it is disclosed (Timms, 2005).

### **The response of families to interviewees' drug dependence**

Once it had been established that the drug user was committed to reducing consumption and was trying to become drug-free, relatives were usually sympathetic. This could be demonstrated by emotional or physical care and the provision of food or money, but often only on condition that this would not be used for heroin. It appeared that it took time to deem a drug user trustworthy once more, and in some cases (8: 30) there was said to be complete breakdown. Several women (10: 30) distanced themselves at this time and family relationships frequently appeared to be complex (Sierk, 1999).

*Alison, 36 years*

*"My family don't trust us no more. I don't go to my mam's - never been close to her, anyway. She knows I'm off heroin now, but we have a bad relationship. She*

*tried to help us again and again, and I threw it back in her face all the time. She put new locks on all the doors to keep us out."*

Interviewees' accounts of their unpredictable and chaotic pattern of drug addiction, frequently coupled with deceit and theft, evidently took its toll on compassionate relatives and coping resources were said to have been sorely tested. Eventually an ultimatum was often issued to cease drug use or contact would be severed, and in a few cases this emotional upheaval was extended over a period of up to fifteen years. Family responses to drug dependence varied, often by gender and position, and the next sub-section will explore these reactions.

### **Responses according to the gender and position of family members**

Frequently (18: 30), it was mothers who were praised for *"being brilliant"* and for their *"unconditional love"*: interviewees declared that they *"couldn't manage without her."* Gillie commented that *"My mum phoned all the help-lines in the country I think, she could be a drugs counsellor herself by now"*. This may have illustrated the level of anxiety involved, as well as a determination to rescue a child from an uncertain fate, and it has been said that a typical maternal response is to develop strategies for the well-being of the family (Donoghoe *et al*, 1987; Dorn *et al*, 1987).

Some interviewees (7: 30) also mentioned the valued support given by their fathers, grandfathers and even fathers-in-law. It seemed that for these women there was greater affinity with a male relative at this time, but interviewees could not identify a particular explanation.

*Pauline, 39 years*

*"Anybody you can talk to helps but my father-in-law is very good - he's my biggest help. I can talk to him about anything and he's got the time. He doesn't understand it, but he tries, and he says 'I want the old Pauline back' and that encourages me. I think I spend more time with him than anyone else at the moment."*

On the other hand, a paternal response of angry retribution and a determination to punish the individual believed responsible for a daughter's addiction, was reported by a few women (5: 30). Liz's father was seriously injured in the confrontation about heroin, and her boyfriend received a custodial sentence for this assault. Liz went on to describe this particular incident in the following

extract, as well as her incredulity that she returned to live with this boyfriend, much to the disappointment and despair of her parents.

*Liz, 21 years*

*"Because my dad found out I was on the gear and came to take me home and they (he and boyfriend) had an argument. My dad was OK in the end, but Dick (partner) got six months for it. There was this knock on the door, and Dick hit him with an axe. But when I went back to him after all that and then continued using, that's when they lost interest, really. Gave up on me."*

It appeared that brothers sometimes took on an adversarial protective role and Gillie said that Peter (brother), "offered to batter this lad to death if he sold us any more - dead against it for anyone". In the following extract, Gemma recalled her family's response to the discovery of her drug use, as well as her own loyalty to drug-dealer friends. This life-long familiarity between addicts and local drug dealers has been said to be typical of the non-urban setting (Henderson, 1998), but may be also be evident amongst city-based addicts.

*Gemma, 27 years*

*"But when Dad and my brother found out I'd been using, they wanted to go and sort out the people who'd been selling it to me. Dad gets really worked up about things like that, he's keen to protect his family. But I never told them who it was, after all, they were my friends."*

There was only one instance where the mother involved had herself been a heroin user, although now on methadone treatment. Moira (mother) explained that her reaction to daughter Jeannie's heroin use was borne out of personal insight and bitter experience of trying to resolve her own drug dependence.

*Moira, 40 years*

*"I mean, I always thought, Jeannie (daughter), has seen what it's done to me, ruined my life - there's no way she'll get into it. And I was quite wrong, and being a user and then being a parent, well, it's a very different story being a parent, I can tell you. When I found out, I knew we were in for a rocky road. It wasn't like any straight parent who thought, 'Oh, we'll just get this sorted'. I knew just how hard it would be. I knew what was ahead of us."*

Jeannie also explained the context of this disclosure to her mother (Moira) and her own incredulity at becoming a heroin user, since both parents had served sentences for supply convictions, and she had witnessed Moira's long struggle with addiction. In this next extract, both women explained their perspectives on Jeannie's disclosure about her initiation into problem drug use.

*Jeannie, 23 years*

*"The people I was using with, I knew I couldn't trust them to keep their mouths shut. David (addict partner) has four sisters and they're very mouthy, like to spread bad news, and then add bits of their own. I just needed to tell my mum myself, because I was well aware that what I'd done, just taking it, was wrong."*

*Moira, 40 years*

*"I said to her, 'Oh, Jeannie, (daughter) please, if you never pay heed to anything else I've said, don't touch heroin, not even once, because you know, once it's in your head, it's hard to get it out.' I'd told her this so many times, and I couldn't believe she was telling me she was on it."*

On reflection, Moira claimed that mutual understanding of heroin use and the difficulties of managing drug treatment had effectively strengthened the relationship between mother and daughter, but this was not in a way that either of the women would have chosen.

### **Summary**

Analysis of interviewees' narratives identified aspects of the women's own family background which may have increased their vulnerability to involvement in problem drug use. Nevertheless, whilst ranking family dysfunction as one of the predisposing factors for their heroin use, interviewees emphasised that this had been their personal choice. On the other hand, some women were adamant that their families were quite blameless, and that they themselves bore sole responsibility for inducing the disgrace of problem drug use. Some women explained that, in their opinion, family reaction was often underpinned by traditional expectations of appropriate behaviour for a daughter, granddaughter or sister (Ettorre, 1992).

Disclosure of drug dependence was always traumatic and risked the breakdown of relationships with parents as well as with siblings: this situation was often a consequence, increasing the interviewee's isolation and heroin 'inundation' (Rosenbaum, 1981a). Nevertheless, after the initial distress, many families rallied round and attempted to provide the necessary support and encouragement for their relative to engage in unfamiliar drug treatment, beset by the frustrations of frequent relapse and disappointment. Where previous relationships had been good, mothers were often singled out for their unconditional support, but eventually some families were obliged to establish

boundaries to protect their own welfare. The role of siblings appeared to offer either enticement to sample substances by virtue of close association and example, or conversely, rejection of the addict sister and resentment of this disruption to family cohesion (Barnard, 2005).

Several women were mothers themselves, or anticipated having their own families as much as any non-drug-users, and they shared views on the impact that their own addiction might have exerted upon children, sometimes as yet unborn. Many interviewees declared their own beliefs about children's unique influence on their mother's drug use: the next section of this chapter will now account for their perspectives.

### **The Influence of interviewees' parental problem drug use**

This section will begin by reviewing what is known about parental problem drug use and its impact on children. It will then progress to describe interviewees' own observations: nearly two thirds of the women (18: 30) interviewed were mothers, and two were more than half-way through their pregnancies. Of these mothers, eleven were currently living with their children, eight of whom had never lost custody of their children. Eight sets of grandparents at some stage, had taken over the care of interviewees' children for varying lengths of time; three fathers had taken custody of their children; two grandmothers had gained custody; two mothers had children in temporary foster care; and one woman's first child had been adopted. Nevertheless, interviewees were willing to comment on this particularly sensitive aspect of their heroin-using lifestyle. The issues they raised included: their professed guilt; their capacity to care for a child; the role of the extended family; and a determination to prevent drug-taking by their own children. The women also commented upon the influences which they claimed that children could exert upon their mother's patterns of drug use: it seemed from their accounts that this could result in changed attitudes and a motivation to become and remain abstinent.

### **Problem drug use and its impact on children**

It is estimated that there are up to 350,000 children living with drug-using parents in the UK and it has been established that parental substance use may cause considerable harm (ACMD, 2003). Children may be exposed to drug use

and dealing, and are at risk of violence and physical and sexual abuse as well as criminality and family breakdown (ACMD, 2003; Keen & Alison, 2001; McKeganey *et al*, 2002). Such harm may also include emotional and physical neglect, which in due course may predispose psycho-social problems as children grow into adolescence (Bancroft *et al*, 2004; Cuijpers *et al*, 1999). Furthermore, these children themselves may be at risk of developing mental health problems (West & Prinz, 1987), or some form of addiction themselves (Bancroft *et al*, 2004; Pandina & Johnson, 1990).

Children of drug users are likely to experience similar socio-economic inequalities as their parents, and to be exposed to the chaos, uncertainty and covert nature of a heroin user's lifestyle (Barnard, 1999; Bourgois, 1995; Hogan, 1998). It has been argued that substance misuse is not necessarily an aetiological factor on its own, but can interact with issues such as socio-economic deprivation or domestic abuse to diminish the quality of child and parent relationships (Cleaver *et al*, 1999). Cleaver and colleagues (1999: 23) have declared that *'To suggest that all parents who suffer from problem alcohol or drug use present a danger to their children is misleading. In isolation, it presents little risk of significant harm to children'*, but they qualify this by adding that *'The best predictor of adverse long-term effects on children is the co-existence of substance misuse with family disharmony'*. The improbability of heroin use occurring in isolation has emerged in previous chapters, and the complexity of influential factors may dispute an axiomatic link between substance misuse and child maltreatment (Cleaver *et al*, 1999). Nevertheless, it seems inevitable that addiction will undermine the ability to parent, and child protection research shows that a high proportion of children who come to the attention of agencies are from families where there are drugs, alcohol, mental health or domestic violence problems, often in co-existence (Cleaver *et al*, 1999).

Research often highlights the inadequacies of drug users as parents and issues raised include those of abuse and neglect; separation; poor parenting skills; and impaired child development (Barnard, 2001; Bancroft *et al*, 2004). Co-morbid psychiatric disorders may in themselves impede good parenting, and it has been said that depression, domestic abuse or psychosis may make the parent *'emotionally unavailable'* to the child (Cleaver *et al*, 1999; NTA, 2002). On the other hand, Kettinger and colleagues (2000) have pointed out that similar

stressful environmental conditions may hamper any woman's parenting, but add that drug misuse in this context may create a serious impediment. Indeed, some commentators have pointed out that not all parents with drug problems will have difficulty caring for their children, but that disruption will certainly be evident when drug use escalates and becomes chaotic (Edmonds *et al*, 2005; Taylor, 1993). Ultimately, the ill-health and premature death of a parent, for example as a result of overdose, will have an enduring impact on surviving children.

### **Drug misuse and Pregnancy**

It has been estimated that at least 30% of problem drug users are women of childbearing age and that the numbers are steadily increasing (Bate & Leggate, 2003; Lindo, 1987; Mountenay, 1999; Siney *et al*, 1995). Substance misuse can adversely affect the outcome of a pregnancy (Chasnoff, 1991; Finnegan, 1988), but it has been said that there is general under-identification in maternity services (Hepburn, 2004). There is greater likelihood of peri-natal mortality and morbidity, often due to low birth weight and pre-term delivery, as well as Neonatal Abstinence Syndrome (NAS), Sudden Infant Death Syndrome (SIDS), congenital abnormalities and the transmission of blood-borne viruses (Dore *et al*, 1995; Hepburn, 2004). In addition, women who use drugs can often be vulnerable to sexually transmitted disease such as gonorrhoea, chlamydia, HBV and HIV (Hepburn, 1994).

However, Hepburn (1996) advises that contributory social factors may have at least an equal role in some of these adverse outcomes, and that many women possess low self-esteem and have financial problems: this is often along with co-existing housing and legal issues (Macrory, 1997). A multi-agency approach to maternity care is recommended, in view of the compounding social factors frequently involved (Hogg *et al*, 1997; Scottish Executive, 2003). Furthermore, Hepburn (2004) advocates a non-directive approach to advice on future reproductive healthcare to avoid alienating a group of women whose chaotic lifestyles often compromise attendance at contraceptive services. Recent guidelines recommend that all women are offered the choice of long-acting reversible contraceptives (LARC) to avoid unplanned conceptions (NICE, 2005b), and this may be particularly appropriate for women addicts, whose disorganized lifestyles may not accommodate regular use of other methods.

Furthermore, the effects of heavy use of opiates often induce menstrual abnormalities such as secondary amenorrhoea, and addicted women may be fairly advanced in their pregnancies before they are aware of their condition (Sparey & Walkinshaw, 1995). Women drug users tend to avoid ante-natal care for fear that their babies will be removed (Ettorre, 1992; Powis *et al*, 2000; Vitellone, 2003), and this can thwart any opportunities for harm reduction advice by specialist staff. This is important because the first trimester, the most critical for foetal development, usually coincides with the most chaotic phase of drug use in the pregnancy, while later substance use tends to affect growth and neonatal addiction (Finnegan, 1988). Nevertheless, Oakley (1992) has cautioned against over-emphasis of warnings about being 'at risk' since this may induce mental health problems in mothers who can find behaviour change at this stage very difficult.

The effect of addiction in the families of children and the unborn has attracted media comment and grave public concern, and interviewees were aware of negative attitudes and associated stigma. Rosenbaum (1981a) has argued that for drug-using women, failing at motherhood equates with failing at womanhood, and that society's censure is directed at mothers more than at addict fathers. Kearney (1994: 6) has observed that *'The image of a bad mother is a terrible, unspeakable notion; a mother using drugs is a clash of values affecting society's sense of emotional and moral security'*, and it seems that society accords drug-using women few rights especially when pregnant (Murphy & Rosenbaum, 1999).

This overview has outlined the gravity of the potential harm to children and the unborn, when living in homes where there is substance misuse. In this study, there was no intention to specifically investigate the situation for children, who were only very occasionally present during or near the interview room, and the main research question focussed on influences on the women themselves. At least in part the children's absence allowed the mother to retain her focus on this session and removed the need to attend to restless youngsters, or to modify her responses if older children were present. It was therefore not possible to pass judgement on whether the interviewees' children were really adequately cared for, or suffering any form of distress. Nevertheless, it did invite speculation as to whether these children, growing up in an environment of

substance misuse, could avoid some form of emotional, psychological or physical neglect. In kind with other examples of this type of research there are limited possibilities of checking whether the women's beliefs were genuine, or events were as described (Moore & Rosenthal, 1993). Moore and Rosenthal (1993) point out that in constructing accounts of personal behaviour, interviewees may create bias by striving for justification: this could therefore be evident where child protection issues could emerge.

### **Influences of motherhood upon interviewees' addiction**

The next section will now move on to describe the issues which the women raised in connection with the influences of pregnancy and motherhood upon their heroin addiction. These included feelings of guilt; assertions of their capacity to care for their children; separation from their children; and the changed role of their extended family.

#### **Interviewees' feelings of guilt**

Interviewees chose guilt as the most common emotion experienced by drug-using mothers (16: 18). For some women (10: 18) this emerged as soon as they realized they were pregnant (Mondanaro, 1988), and even for some non-drug using women pregnancy can be an unwelcome surprise (Oakley, 1979; Kitziinger, 1978). It has been noted that there are high rates of unplanned pregnancies amongst female drug users (Donoghoe, 1992), and that women in general find it easier to adapt to pregnancy and motherhood if this is not the case (Cutrona & Suhr, 1990).

In the following extract, Elaine explained her guilt about using heroin in the months before she discovered her pregnancy, and confessed that she still was still smoking some heroin in addition to the prescribed methadone. However, Elaine had already noted some changes and attributed the influence of pregnancy upon her new attitude to drugs and the associated lifestyle.

*Elaine, 24 years*

*"And then I got pregnant last May, but I didn't know until I was 4½ months gone. My periods had stopped and I thought I was in too bad a state to get pregnant, and he was in bad shape too, so we didn't think it could happen. At first, devastated. No, that's a terrible thing to say. I'm sorry, bump! I was shocked - I was very surprised. I really thought that with all the abuse I've given my body I didn't deserve to have any children. To be honest, I'm having a bit of a problem letting go with the heroin. It's like having a love affair with it, isn't it? At the end*

*of the day, it's still the most important thing in the world. Now though, all my priorities are kind of changing. For me, now, food is more important, and it never was when I was on heroin. Even if I was starving, and I had a tenner, I'd have gone for heroin. But now, it's the other way round. For me, that's just amazing, and I'm beginning to see a change in myself. Maybe it's the pregnancy, and having someone else to think about. I think it's my own state of mind as well, being pregnant, that's put my mind like it is."*

It has been asserted that stabilization, in order to prevent the use of non-sterile equipment or illicit drugs, is the most realistic goal for pregnant women (Johns, 1988), and that urine screening is inappropriate at this time (Hepburn, 2004). Furthermore, Hepburn (2002) has argued that the aims of prescribing methadone for pregnant women differ, and that the plan should be to reduce overall drug use to the lowest level compatible with acceptable stability. Hepburn (2002) has said that many women, motivated by the desire to minimize NAS, often continue to reduce methadone throughout the third trimester, to levels which are not sustainable post-delivery. She has cautioned that this must then be addressed when women are already experiencing the stresses and strains of early motherhood. Furthermore, recent expert advice has suggested that pregnancy alters the metabolism of methadone, with a much shorter half-life, and that women should be advised to take it in divided doses to mitigate this effect and the physical manifestations of drug withdrawal (Jarvis *et al*, 2000; Lofty, 2003).

Elaine expressed frustration at not having the chance to negotiate her treatment regime with her drugs worker, and said that that struggling with withdrawal symptoms then served to increase her guilt. She went on to describe unsatisfactory interactions, and the discomforts to both mother and foetus of trying to manage her methadone treatment during pregnancy. It was confirmed that a drug liaison midwife was not yet available in North Cumbria to enhance good practice and care for pregnant drug users and their babies, and to support health and social care professionals (Clark & Formby, 2000; Macrory, 2002).

*Elaine, 24 years*

*"I'm not cutting down on the methadone yet, but it's rather difficult, really. Because I'm still using, I actually feel that I'd like to go up a bit. In the last six weeks, every time I ask I know I'm not on the right level, but they say 'No, not even another 10 mls.' I could have been stable and thinking of reducing by now. It's like they (drug worker) want to keep you on it for ever. 'Give it time,' they say, 'another two weeks. I know you can't stop, but never mind.' Hopeless. Soon it's*

going to be too late to go up, and then I've got no chance of coming down and getting to a decent level so that the baby won't suffer and withdraw. Why won't they help us like that, it's like I've got no idea what my body feels like? I'm really wanting to be able to sleep, that's the main thing that's bothering me. It makes me quite angry that they won't agree to what I think will help me. I've tried Horlicks, cocoa, reading a book, having a bath, everything, all the tricks. At four a.m. I'm uncomfortable, ready for my methadone, and if I'm uncomfortable, then the baby will be too. I'm really worn out with it."

### **Interviewees' guilt in early motherhood**

Other women (6: 18) recalled feelings of profound guilt when their new-born infants were admitted to the Special Care Baby Unit. Sue was one interviewee who tearfully described the trauma of witnessing neonatal withdrawal syndrome when visiting the ward before her delivery, and she said that just observing this had stimulated her desire to end her drug dependence.

*Sue, 32 years*

*"You know, they took me on the ward, Special Care Baby Unit and all that. There was a baby there, one day old, and in bad withdrawals. I just cried my eyes out. It was sickening, I felt so guilty. With Jamie (son), just a sneeze and a shiver, and he was nearly five pounds, too, so I was pretty lucky. I wouldn't wish any baby to go through what I saw that little baby going through. It was horrible, horrible. I had to get my detox to work. That was my motivation."*

Sara reflected upon similar experiences and also spoke about her apprehension about motherhood, which she said was rapidly dispelled after delivery.

Mondanaro (1989) has noted that many drug users appear to deny the reality of their babies until they are born, as well as the need to make practical preparations (Finnegan, 1981), and it has been suggested that this may relate to deeply held fears for the child's survival (Taylor, 1993).

*Sara, 26 years*

*"Although I was pregnant, I had no vision of having this child until he was born. And then he was there, and it all hit me then, what I'd been doing, the risks I'd been taking, and him in the Special Care. You know, I didn't think I really wanted a kid, I was quite scared of them really. I never thought I'd manage, but when Timmy (baby) was born, mothering came over me, I was really proud of myself."*

Gemma described the impact of seeing her child in an incubator and the strains of the immediate neonatal period, and she declared the depths of her culpability. Babies with neonatal withdrawal symptoms such as: high-pitched crying;

disturbed sleep; and vomiting and diarrhoea can be difficult to care for and it has been said that this can interfere with bonding (Coleman & Cassell, 1995). Klee (2002b) has argued that health professionals may claim that the mother's guilt is short-lived, and that behaviours interpreted as demonstrating lack of caring can in fact be coping strategies for feelings of failure. Fowlie and McHaffie (2004) have claimed that Special Care Baby Units can be stressful for any parents, and that their responses may differ by gender, but have asserted that appropriate support for vulnerable parents should be an integral part of neonatal care. This next extract accounts for Gemma's description of her own experience, and she declared that the distress for the whole family prompted her to address her drug dependence.

*Gemma, 27 years*

*"Zoe (baby) was in Special Care on Largactil at first, but she was twitching, so they stopped that, and then it was Oromorph, and she improved daily, or else they said they'd have to get the paediatrician. She had one bad day, screaming constantly, it was so awful, and I was terribly upset. I signed myself out after three days, and they said I should still be in because my blood count was still very low. But I wanted to get home to comfort Robbie (son). He was dreadfully upset with it all, so I came in to be with her 9 till 8 at night, and she was improving all the time. And then even that horrible nurse came round when she could see that the baby wasn't harmed and was responding. Zoe was only in four weeks, my mate's was in twenty."*

A few women (4: 18) disclosed that the infant's admission to the Special Care Baby Unit also provoked anxiety about unplanned revelation of their heroin use. Gemma went on to explain that she had managed to keep her drug use secret from close relatives and that most of the staff had been supportive, but nevertheless this fear had added to the tensions of the situation.

*Gemma, 27 years*

*"So there was all that to contend with. I mean, his (husband) mam didn't know I was on methadone and still doesn't to this day. 'Why was Zoe in hospital?' But at least I could say that she was early, and so that got us off with that. I mean, most of the nurses there were spot on, but that Nora really blamed us. Zoe's come along great, suffered no harm from it."*

On the other hand, Sara's experience was less discreet and a member of staff's disclosure caused shock and anger within the immediate family, who were unaware of the extent of the couple's problem drug use.

*Sara 26 years*

*"When he was born he had a low blood sugar level and he had to go to Special Care for 12 hours. Liam's (partner) sister came to visit, and the Sister said, 'Oh, you haven't told her the real reason the baby's in here? You haven't told her he's withdrawing?' I wanted her job for that."*

Klee (2002) has pointed out that unless women are made aware of an information sharing protocol to protect confidentiality this fear of disclosure becomes an area of suspicion and mistrust. She says that most lapses will be unintentional but can cause serious breakdown in personal relationships, and can *'become part of the folklore of drug-using networks'* (Klee, 2002: 265).

### **Interviewee's guilt about childcare responsibilities**

Feelings of remorse apparently persisted long beyond the stages of birth and infancy and most mothers (14: 18) now expressed deep shame at the way in which drug use had taken priority over childcare responsibilities, as well as family life. In addition, it has been argued that parents need the motivation and energy to respond to the demands of an active child and these can be seriously challenged by the effects of heroin, or structural pressures associated with substance misuse (Harbin & Murphy, 2000; Klee, 1998a). Rosenbaum and Murphy (1990) have emphasized that any interventions for drug-using mothers should accommodate parenting support and skills training, often by referral to appropriate agencies. They have commented that, for the drug-dependent mother, strengthening her ability to parent may be a vital step in her eventual recovery. Lara was one interviewee who praised some dedicated work by a national children's charity's family support worker, which she said had helped her to develop parenting skills. She also remarked that she was now appreciating aspects of family life which heroin use had obliterated, and she believed that her children had already benefited.

*Lara, 28 years*

*"You can hide away or face it, and for me it was the kids, realizing that they were the greatest gift in life for me, and I needed to look after that and not risk losing it. Once I felt I couldn't cope with being a mum, and now I love it. It's about getting up and seeing their little faces. We went horse-riding last week for the first time, and they were all so happy, it was wonderful. Doing things with them, having some fun, that's what's really important. I've just done a cookery class at the*

*local school, and I'm doing another one in September. I never used to go there because I was so ashamed, but now I can hold my head up."*

Despite confiding these persistent feelings of guilt, many interviewees went on to discuss their ability to care for a child as a mother who was dependent on heroin, and the next sub-section will account for their views. Issues relevant to their capacity to care included the presence of domestic abuse within the family and the self-involved chaos of an addict lifestyle. The researcher was not, for the fore-mentioned reasons, in a position to make an objective assessment of this ability, nor whether the children had been or were suffering substantial neglect because of their mother's drug dependence, although that question remains. The women's narratives indicated that at the very least her attention and supervision must have been diverted by the pressures of maintaining a heroin addiction.

### **Interviewees' capacity to care for their children**

Inconsistency, neglect and an impoverished environment have been noted as key factors in delayed child development where substance use is present, and a chaotic lifestyle may compromise appropriate care (Harbin & Murphy, 2000). Furthermore, Markowitz (1993) argues that the ability of drug-using parents to relate to the needs of their children must be impaired by the effects of the substance, and that this can be reflected in the way their children display low self-esteem and feelings of blame. On the other hand, Taylor (1993) argued that the women in her study were attempting to do the best for their children, as most mothers do (Henderson, 2004). When their addiction was affecting their capacity to care, Taylor (1993) observed that her interviewees sought alternative solutions, and commented that women who failed to provide adequately for their children were despised by their peers. Taylor (1993) went on to argue that her interviewees held traditional values in terms of their expectations of the fulfilment and duties of motherhood, and experienced guilt and anxiety if they failed to achieve this.

Many of the interviewees who were mothers (8: 18) reacted quickly to assert that their ability to manage their childcare responsibilities was unaffected by heroin

use (Laybourn *et al*, 1996). Interviewees explained, for example, that *"we always used when the children were asleep"* or *"we used at the weekends when my Mam has them"*, and similar protective strategies have been noted elsewhere (Goode, 2000; Kearney *et al*, 1994). It was not possible for the fore-mentioned reasons for the researcher to verify or challenge these assertions. Nevertheless some interviewees (7: 18) were prepared to admit that for example, the strains of withdrawal were testing times, and increased irritability is characteristic of this state (Kroll & Taylor, 2003). Parental preoccupation with drugs can be detrimental to the relationship with their children, and it has been reported that drug-using parents can tend to use aggressive forms of discipline, sometimes linked with the co-existence of domestic abuse (Sumnall *et al*, 2006). Sara confided that she was often short-tempered, but claimed that her appeals for support from health professionals had been ignored.

*Sara, 26 years*

*"Say you had three days on, and four days withdrawing, I found myself shouting at Timmy (son). I hated myself, that's what made me go for the methadone, that one time I shouted at him. It's crazy, they say, 'we don't want to put you on one addictive drug on top of another'. But they'll put you from heroin on to methadone, no bother. They won't help you when you want something for your nerves to stop you shouting at your kid. Stupid."*

Constant care for small children can be tiring for any parent: many women have used prescribed drugs to help them to cope (Brown & Harris, 1978), and therefore a return or escalation of heroin use may have had a functional component. Sara went on to intimate that looking after son Timmy single-handed could be stressful and that she felt isolated, and guilty about those thoughts. Nevertheless, she acknowledged that the support she needed was more social in nature than pharmacological, but claimed that her requests for help from health services had been rejected. Bate (2005) has argued that a specialist health visitor working with drug services could give valuable help to drug-using mothers with issues such as: parenting skills; living on a budget; self-care; bonding with a new baby; and contraceptive advice.

Sara went on to explain her fierce resentment of the interference of suspicious neighbours, and of their accusation that she was an inadequate mother, proudly describing the outcome of an unexpected visit by a Social Services team.

Sara, 26 years

"Somebody phoned Social Services twice, said that I had dog-mess all over the house and that I had no food for Tim (son) and my and my house was full of junkies. All rubbish and lies, all of it. I burst out crying when they came to my house. I went to the cupboards and pulled out every jar and packet of food, packets of nappies, everything. And they said to me, look, Sara, don't worry, we can see, we can see that he's a happy child and you've got what he needs and that your house is clean. I mean, I didn't even know they were coming or anything, they just appeared. One of the neighbours didn't like us, never found out who."

An additional factor which interviewees sometimes mentioned in the context of their caring capacities was that of domestic abuse: a half of the mothers (9: 18) confided that they had suffered this experience. The next two sub-sections will consider the impact of both this disruptive home environment and that of chaotic lifestyles on the drug-using mother's capacity to care.

### **Impact of domestic abuse on interviewees' caring capacity**

Kettinger and colleagues (2000) have affirmed the adverse effect of factors which often characterize drug-using women's lives, such as poverty, isolation, depression, homelessness and domestic abuse. Any or all of these in combination may seriously impair *bonding and attachment*, as well as limit any woman's ability to parent her child by making her *emotionally unavailable* and overwhelmed by personal difficulties (Cleaver *et al*, 1999; Jaffe *et al*, 1990; Perry, 1997). Moreover, it has been noted that there is a significantly increased risk of domestic abuse and child maltreatment where substance misuse is present (Bays, 1990; Velleman, 1993; Velleman & Orford, 1999). Hester and colleagues (2000) assert that this type of violence in the home results in the most serious harm to children of all ages, and substance misuse in survivors may in itself be a response to such abuse. Furthermore, Hester and colleagues (2000) argue that these interacting influences and processes may greatly exacerbate adverse outcomes for children. Whilst it was reported that at least half of the mothers (9: 18) had experienced this type of victimisation, it may now be more appropriate to conceptualise them as '*survivors*' rather than '*victims*' of their perpetrators, since it has been asserted that women's empowerment and self-determination are important principles for recovery from domestic abuse (Hague & Malos, 1998).

Aware that her children had frequently witnessed violence in their home, Lara intimated her dismay at watching her young son model his father's aggressive

behaviour. She confided that it was only then that she then realised the full impact of domestic abuse upon her whole family.

*Lara, 28 years*

*"Well, you know, my little lad started hitting me. I was so shocked. First time I smacked him, and it was only started when Sean (his father) came back. He's (son) nearly four now, and even though he was a baby when Sean was living with us, I think they have slight memories. I think he had a flashback and lashed out at us. He punched me and it really frightened me. I told him you don't hit girls and that's why your dad got jailed. I never hid that from them, and one day he looked through the railings at school and told everybody, I'm in jail just like my Dad. It was comical like but it frightened me."*

Lara went on to explain how all five children had been affected by their unstable home life, but that therapeutic work was proving beneficial for some of them.

*Lara, 28 years*

*"I know my kids are still affected, really. They go to the children's charity place: my oldest couldn't cope, she used to sit and scream, but the second-oldest did benefit. Kelly, she can write it down as a letter, but she can't talk about it. I think she's a bit like me as a child. When I was young, I couldn't talk about how I felt, and I think that's why I took things so hard. Leanne, the oldest girl, was lashing out in school because they were calling her names, saying her mam was a smackhead. I had to sit her down and say it was true once over, but now you can say your mam has beaten that and you're proud of her, and she's been OK since."*

Children living with addicted parents have frequently been shown to display similar problematic patterns of behaviour, including Attention Deficit Hyperactivity Disorder (ADHD) and aggression (Ornoy *et al*, 1996). Emotional and behavioural problems often appear to be linked with feelings of helplessness and loss of personal control, which may have adverse sequelae in adolescence, such as: truancy; teenage pregnancy; and anti-social behaviour (Dore *et al*, 1996; Ferguson & Lynskey, 1998; Kandel, 1990).

Lara said that it had been difficult to access any assistance with this domestic abuse, which was enmeshed with drug-related activities, and compounded by her partner's parents' intimidation and threatened reprisals. Drug-using women often fear that they will be blamed by helping agencies (Philip *et al*, 1997) and it appeared that this also influenced interviewees' help-seeking. Lara reported that she had sometimes suffered serious injuries requiring medical assistance, but

current guidance now recommends routine enquiry about domestic abuse of any women who present with unexplained injuries (DH, 2006; Itzin, 2006; Taket *et al*, 2003). Furthermore, gender-sensitive training for drug agencies to provide or enable support for survivors of violence has recently been advocated (McKeganey *et al*, 2005).

### **Coping with chaos: the impact on interviewees' caring capacity**

Intoxication inevitably affects the capacity to care and the parents' need for drugs will often supersede other demands, therefore children may sometimes be left with unsuitable carers (Allison, 2000; Swadi, 1994). It is evident that when parents are under the influence of heroin, children cannot be properly supervised, and despite claims that drugs were only used when the children were asleep or cared for by relatives, some women (7: 18) did acknowledge that there were times when they had been at potential risk. Linda had been charged with Child Abandonment and Wilful Neglect when her children were found alone by police after their father was arrested for a separate offence: the children were then removed to temporary foster care. In the following extract, she tearfully recalled her version of the events of that night, when babysitter Roy had left the children alone, apparently thinking that Linda and husband Ryan had already returned home from an evening with addict friends.

*Linda, 23 years*

*"Well, he (Roy, babysitter friend) was looking after the kids, right? I've known Roy since I was at school. And the police went searching our house and found the kids on their own. I think I understand how it happened. Roy wouldn't have left them if he hadn't genuinely thought he heard us coming home. I mean the next night when I got back Ryan (husband), was still in the cells. I went right home, and there was her little dummy in the bed, and the toys they'd been playing with. I just broke my heart and fell asleep. Roy would never let us down, he made a statement and everything, saying he was babysitting that night and everything. I was there and heard it."*

All of the mothers pronounced love and care for their children and a few (4: 18) explained that their partners or husbands were equally committed. Kitty pointed out that when she was sent to the Bail Hostel following a custodial sentence, her husband willingly attended to the children's needs. Klee and colleagues (1998) also found that many drug-using mothers emphasized the father's role in supporting them and sharing the care of any children. Kitty went on to explain that she made an eighty-mile round trip by bus on a daily basis, leaving early in

the morning and returning to the Bail Hostel after the children's bedtime, to try to maintain normal routines. However, she did acknowledge that the couple could not have coped during the most chaotic stages of their heroin 'career', if her mother-in-law had not voluntarily taken their children into her home. This type of informal care was the preferred choice for interviewees, but in a few cases (4: 18) statutory agencies had intervened and this was generally dreaded. The next sub-section will consider the impact of separation on both the mother and her children.

### **Interviewees and their children: separation and loss**

It has been noted that the children of drug users may often suffer reduced quality of attachment to their parents, and to suffer from episodes of separation and loss (Hoffmann & Cerbone, 2002). This may be as a result of long periods in treatment, but may also relate to the concerns of statutory agencies and the need for foster care. In this study, three fathers had taken over the care of their children; two grandparents had gained custody and two interviewees' children were currently in temporary foster care.

Those mothers (7: 18) who were not currently living with their children, said that they made great efforts to maintain contact where possible. Linda's two children were being cared for by temporary foster parents, and she confided her sadness and frustration that her attempts to preserve the family relationship, by providing gifts and mementoes, had been rejected. Aldridge (2000) has commented that drug-using parents can sometimes over-compensate from feelings of remorse and try to provide children with everything they themselves had been denied, which resonates with Linda's account and the observations of local drug service staff (NCABS, 2005, personal communication).

#### *Linda, 23 years*

*"They're three years nearly, and five. When the children went to temporary foster care, I got some copies of these photos done and put them in a little book for them, and we got new clothes and all that for them. Every time we go to visit them, twice a week, I wouldn't agree to once, we take them brand new toys. I know it's only material things but we've always liked to buy them things. They like us to be together all the time. And do you know, when we next went to visit them, they had complete new outfits, she'd bought them everything all over again, and she gave me back this little parcel with the photos. Couldn't even let us have that much."*

A compromise arrangement, which was agreed by a few families, involved grandparents (2: 18) taking over custody of any children. However, many mothers (14: 18) also mentioned temporary child-minding, treats and necessities provided by grandparents. Care-giving by families was seen as both preferable and less stressful than statutory services' involvement, and nearly half of the mothers (8: 18) had handed over caring responsibilities for their children to grandparents for varying lengths of time. In this extract, Alison shared her views and frustrations about the interventions of statutory services.

*Alison, 36 years*

*"Social Services is the big problem. I couldn't get the kids back until I've got a house, and then I couldn't get a house because I didn't have the children. Why come off it if you can't have your kids back? I know some people that have lost them, and some haven't. No rhyme or reason. It's just not fair. That's a big thing that stops women coming for treatment, Social Services stick their noses in too much. My youngest one is still living with my mam. He's 11 now and we have a really good relationship. He comes over to stay here sometimes. He has the bed and I have the sofa. But it's harder to see him, because she's 10 miles away. I miss him an awful lot."*

Child protection concerns meant that Lara's fifth baby was taken into care just after birth, and she described her distress and subsequent outrage at apparent neglect by foster parents. She succeeded in having the baby transferred to her own mother's care, and a Residency Order was still in place. Lara believed that this was a satisfactory solution, and regular contact was established. In this extract, she tearfully recalled her version of the traumatic experience of Alice's birth, neonatal period and temporary foster care arrangements. Lara was insistent that it was witnessing the baby's neonatal abstinence syndrome provided the impetus to seek help for her heroin addiction.

*Lara, 28 years*

*"The hospital were really good to us. When they took the baby away, two of the nurses cried. I used to get up at night and talk to the nurses and they let me be her sole carer. I didn't want the nurses to have to give her medication. 'No, it's me that's put her through this, I want to care for her'. I was walking up and down all night sometimes, comforting her, because she'd get these times when she'd just tremble, I was petrified (whisper). At first, I didn't know what was happening. They said it was the withdrawal, but I didn't have tremor like that. It all seemed to happen like a dream, like a nightmare. Delivered her myself, the ambulance didn't come for hours. I thought they knew it was just a junkie. And the Social Services came to the hospital and threatened us that if I tried to take her out I'd get arrested. I was all on my own and she was in Special Care, so we were separated, but this young nurse let me in to watch her. And then Social Services*

*said she wasn't allowed to sleep in my room, it was only the last night they allowed it."*

Lara went on to account for her outburst when it appeared that (baby) Alice was not receiving appropriate care from the foster parents, and pursued her case with remarkable tenacity until the baby was returned to her own mother's care.

*Lara, 28 years*

*"I had to meet the foster carers there with her, and I gave Alice a bottle and went to change her nappy, and she was all blistered and bleeding and sore. Well, I went mental that they weren't looking after her properly. The next thing I was told, she was to be moved, and I ranted and raved and said, 'You're not taking my babby nowhere else.' It was all to go through again. I got my solicitor behind me, and said I wanted her to me or at least my mam. But they did say, I could get her back some time. And it's turned out a good situation, her living with my mam. I see her every day, and she couldn't be better cared for. It'll help if I can get a job, and that will be easier with my mam looking after her too."*

Other interviewees (10: 18) were prepared to concede that managing motherhood and an addiction was extremely difficult and some women (6: 18) said they had approached statutory childcare agencies themselves, claiming to be *"not a fit mother"*. Jo went on to describe the background to this decision, which had intensified her determination to seek help and to succeed with drug treatment.

*Jo, 30 years*

*"It was difficult days when you had no gear. Those were the hardest days, but it wasn't too bad apart from that. I contacted Social Services, so I brought it on myself. I needed to break the cycle, so it was me who got on to Social Services because I didn't want them to suffer and fear like I had with my alcoholic dad. I'm heartbroken really, but it's not fair for me to have the kids. I understand all that part of it why. The kids deserve better and they're with their dad until I've straightened myself out."*

Sometimes interviewees commented on children known to them who had been forcibly removed into Local Authority care, but they complained that there appeared to be little consistency in the way that this decision was implemented. The Children Act (1989) Section 17 requires Local Authorities *'to protect the welfare of children in need, and as far as this is commensurate, to provide a range of services and promote inter-agency working, in order to permit care by the family involved'* (DH, 1999a). Where there is concern about significant harm to a child, under Section 47, action to intervene may be taken immediately with a Care or Supervision Order, or after a case conference, and then the child's name may be

placed on a child protection register. Lara believed that all five of her children were to be removed into statutory care, on account of concerns about domestic abuse and parental drug addiction, and admitted that this threat had prompted her suicide attempt. She went on to depict that scenario and her current relationship with her young family, which might indicate the beginning of a 'parenting role' being adopted by her children (Bekir *et al*, 1993). In the event, only the two girls were taken into temporary foster care, but they have now returned to live with their mother and two brothers.

*Lara, 28 years*

*"And the thing was, they decided to only take the girls, and there was no suggestion of sexual abuse either. There was no logic in it. I nearly succeeded, and all I told them was, I fell on a bottle and never told them I'd slashed myself but my mam knows now. I felt very guilty, but I'm only beginning to start telling some people, I'm starting to deal with it. The lads have been a great support for me. Even my youngest will say 'what are you crying for, you silly sausage' and he lifts my spirits so high, and he's only three. He demands love: they're all really demanding, asking for a cuddle all the time, but I'm happy for that. They all like a lot of kisses and attention. It's made such a difference to them, getting shot of him and heroin. They come to me all the time now. We have such a good relationship now."*

Bekir and colleagues (1993) have observed that children of drug users may often either take on a parenting role or become withdrawn and display behavioural problems. They declare that those who 'parent' their parents at least in some aspects of family life tend to suffer most, and this group was predominant in their study (Bekir *et al*, 1993).

Many women (11: 18) were currently living with their children, but were acutely aware that they were being closely supervised by the health and social care professionals with whom they were in contact. Researchers have noted the anxiety this causes for drug-using women and the barrier that it can create for the mothers' access to healthcare (Faugier & Sargeant, 1997; Philip *et al*, 1997), although the safety of children must always be paramount. Gemma explained some of the reasons that this was stressful for her, as well as her belief that an unsatisfactory interaction with a drug worker was intensifying her depression.

*Gemma, 27 years*

*"But two weeks ago my drugs worker phoned Social Services again because she thinks I've got Post-natal depression with all that's going on. You can't trust them."*

*It really makes me sick and angry too. It makes me feel that I can't cope after all, like I'm a bad mother. I mean all mothers feel a bit low sometimes – you get tired with all there is to do, don't you? But you pick up from that. I mean when you wake in the morning and see their little faces looking up at you, it makes it all worthwhile. I love them both to bits. I've just picked up this prescription now – it's ironic isn't it? I'm now being given drugs to cope with the people who are helping me. I think this is what's getting me down. I don't need to be told I'm a failing mother – not just now – I'm trying my very best."*

Negative stereotypes surround maternal substance use and are known to be a deterrent to drug-using women's use of services (Hepburn, 1997, 2000; Klee *et al*, 2002; Kroll & Taylor, 2003). However, Hepburn (2000; 2004) has argued that most pregnant or new mothers want to do the best for their babies, and that setting achievable goals which promote self-esteem and minimize the risk of failure can be the most effective approach for addicted mothers.

An indirect effect of the impact of heroin use upon the women's relationship with their children was the role reversal that often occurred within the family (Orford *et al*, 1998), and the next sub-section will discuss this feature.

### **The changed role of the extended family**

It has been remarked that role reversal is often adopted within families where substance use is present and that grandparents sometimes take on parenting duties, due to various aspects of family dysfunction (Orford *et al*, 1998). The women in this study often indicated a similar situation and this will now be considered.

Barnard (2003) has commented on the strong underlying cultural ethos which gives credence to care given within the family (Cramer & McDonald, 1996). She argues that this assumption denies recognition of pre-existing instability in that environment (Klee *et al*, 2002), and others have highlighted the need to acknowledge substance misuse problems within this extended family (Bancroft *et al*, 2004). Interviewees sometimes recalled dysfunction in their families of origin, sometimes derived from physical, emotional and sexual abuse as well as parental alcoholism. In one instance, it was revealed that an interviewee's childhood sexual abuse took place in collusion with her mother, who had recently been granted custody of her two grandchildren. Barnard (2003) has

cautioned against a supposition that the care of relatives is necessarily the best solution for a child placement. Nevertheless, she concedes that without this type of intervention, the option of either continued exposure to a drug-using environment or else entering local authority care, may also result in adverse outcomes (Newburn & Pearson, 2002; Ward, 1998; Ward et al, 2003).

In some interviewees' families (7: 18), grandparents had taken over the care of the children of their own addicted daughters, and less frequently (1: 18) the children of their sons (Tyler et al, 1997). In some cases, this began as short-term episodes of care to protect young children during periods of chaotic drug use, but for other grandparents (2: 18) this support extended into children's adolescent years. These children had often been taken into the care of relatives with the formal approval and recognition of statutory agencies, to ensure a place of safety. In some instances, (8: 18) contact with their birth mother became intermittent, and grandparents had intervened either because of her preoccupation with heroin (4: 18) or as a result of custodial sentences (4: 18).

There were several claims of grandparents "*enjoying the children's company*" and providing both necessities and treats, often made inaccessible because of the demands which heroin made upon the family's income. However, the emotional and behavioural impact of parental drug use has already been noted (Ornoy, 1996), and this may increase the burden and tensions of caring for the children of relatives (Barnard, 2003). In the following extract, Ellie described her parents' intervention, and the way she now acknowledged she had abused their goodwill.

*Ellie, 23 years*

*"Well my Mam took him (son) because she thought I wasn't coping very well. But then Social Services realized it wasn't just depression and it was heroin. But I never got stopped seeing him and I can only be thankful for that. When Nicky (son) was small, I had all his Family Allowance and I didn't have him to look after so that was £100 a week straight off for heroin and I borrowed off my poor family – they didn't deserve it at all. I feel so guilty that my son had to go and live with my Mum but at the time I couldn't see it, and it's easy to say that afterwards. At the time you're just selfish - I was only sixteen – and all I wanted was the hit."*

Timms (2005) has pointed out that grandparents may have to cope with increasing demands for children's expenses when their own financial resources may be diminishing, and that local authorities have only discretionary powers to assist kinship care. This specific form of 'unplanned parenthood' (Minkler *et al*, 1993), quoted by Barnard (2005), may therefore place additional financial as well as physical strains on grandparents. In the following extract, Michelle also described the extensive financial outlay her parents and her husband's mother made to divert the couple from criminal activities and to allow them to buy heroin. She expressed her gratitude for their generous support for the couple, both in time and money, but was now appalled at the family resources which had been squandered.

*Michelle, 25 years*

*"They've (parents) been wonderful – devastated like at first. But they haven't written us off or anything. They've helped all they can. They have the children every weekend and on Thursday night so that we can get out for a bit, go for a meal. We don't go drinking any more because we'd meet all the wrong folk. My parents, Liam's (husband) mam too, even gave us the money we needed to stop us getting into crime. I'm glad that isn't something I have to face but I'll never be able to pay them back. It makes me quite ill to think how much we spent. All the spare money from the housekeeping, all our benefits."*

It often seemed that from their current position, full recognition of the devastating impact of heroin use reinforced interviewees' conviction that their own youngsters must be protected from engaging with problem drug use. The following sub-section will account for their opinions on drugs prevention.

### **Prevention of drug use in their own children**

There was general agreement that mothers did not want their children to become enmeshed in lifestyles similar to their own. Nevertheless, it has been asserted that the children of drug users are at particular risk of developing drug problems themselves and of experiencing harm (Hoffmann & Hsu, 1998; Johnson *et al*, 1990; Lloyd, 1998; Barnard & McKeganey, 2004). Furthermore, it has been suggested that this tendency to substance misuse can persist into adulthood (Velleman & Orford, 1999). Most of the mothers (16: 18) shared a belief that if children had witnessed the destructive impact of heroin within their family home this would act as a powerful deterrent. Jeannie's account bore testimony to the

fragility of the assumption underpinning Moira's (addict mother) repeated entreaties to avoid drug use, as the following extract illustrates.

*Jeannie, 23 years*

*"Funny, but you see, I've been brought up with drugs. I mean, my mum and dad were both addicts, I grew up with heroin and knew about it long before I took it. For me, knowing about it wasn't enough. I knew what it did to people, and in a funny way that made me want to know what could be so good about it that people could take those risks. I thought, I'll take it once, and I'll never ever take it again. You always think you'll be different. But no, I had to have another go and then another go and then it got hold."*

Basing their strategies on a similar premise, most of the mothers (16: 18) said they would talk to their children about their personal experience of heroin's destructive effects and about their own regrets, in order to discourage them. Gemma's comments, in the following extract, were typical of other mothers.

*Gemma, 27 years*

*"It may sound mad but in a way I'm pleased that I've been through all this because now I can advise my kids better. If your mother or your teacher told you something, you'd say 'Oh yeah, yeah.' But when someone's had first-hand experience, it makes it different. God bless my mam, she's tried her best but she's a different generation. For my generation drug culture is no big deal – normal – weekend Ecstasy and all that. It's everyday life, even for upper-class people. Lecturing doesn't work but I can explain in a different way I hope. I want a better life for my kids – the best of everything."*

One interviewee explained her use of 'shock tactics' to discourage her son's early experimentation with cannabis, by giving him a large enough quantity to induce nausea, but only the passage of time will provide evidence of the effectiveness of her approach.

In addition to interviewees' recognition of the implications of their heroin addiction for child welfare and a stable home life, they often attributed the motivation to seek help to factors relating to their children. The next section will now progress to account for what women said about the influence their children themselves exerted on the course of their mother's addiction: many interviewees described this as a unique and powerful effect.

## **The Influence of Children on their Mother's Addiction**

This section will consider the issues that interviewees raised about their children's influence on a mother's continued drug use, and will describe what they said about this effect. It seemed that this pressure for change could first arise during pregnancy, in order to reduce harm to the unborn foetus, or subsequently to try to minimize the effects of parental drug use. In addition, interviewees claimed that renewed commitment to their children could often motivate adherence to a treatment regime. All of the mothers (18: 30), and those whose pregnancies had been confirmed (2: 30), asserted that regard for their children was a significant incentive to modify drug using behaviour, and similar findings have been noted in other studies (Hepburn, 2000; Klcc, 2002; McIntosh & McKeganey, 2002).

In particular, pregnancy is often regarded as a time when many women in the general population re-assess health behaviours, and although Siney (1995) found no evidence for any change in women's drug use, there was an adaptation of lifestyle. On the other hand, Lewis and colleagues (1995) have pointed out that pregnancy can be a time of ambivalence when some drug-using women experience distress, anxiety, helplessness and isolation, and it has been noted that motherhood is still defined by powerful social prescription and expectations (Ribbens, 1994).

As soon as pregnancy was confirmed, however late in gestation that might be, several interviewees (8: 18) said that they had tried to reduce drug consumption, or to change the pattern of their drug use in some way. A few mothers (3: 18) claimed they had managed to abstain then, but Elaine gave an example of harm minimisation, and explained that she was proud to have overcome her 'needle-fixation' at this time (McBride *et al*, 2001; Malloch, 1999).

*Elaine, 24 years*

*"No, it's one thing I've managed to do, stop injecting, since I've been pregnant. A very big step, because I had such a big problem with the needle, a fixation. I used to inject water if I didn't have gear. Just a ritual, the whole thing was just a ritual, getting the gear, cooking up, drawing it up, finding the vein, pinning your arm, all of it a ritual. I can imagine it now, but I've put that behind me. It's so much easier to go over with that, but not with the baby. I'm not taking that risk."*

A few other interviewees (3: 12) who anticipated becoming mothers at some time, held strong views on substance use during pregnancy, as well as confidence in their ability to overcome dependence then. Rosenbaum (1979) found that her interviewees were often consumed with guilt if they were unable to resolve their addiction for the sake of their unborn child.

*Sharon, 22 years*

*"I've got a mate who used gear all through her pregnancy, and the baby was rattling when he was born. I was disgusted with her. That's something I could never do, put a baby at risk like that. Andy (partner) and I want to have a baby, we have been trying really but if I was pregnant I'd stop heroin just like that. No way would I put my child's life at risk."*

### **Motivation to change behaviour**

Mothers consistently claimed (16: 18) that it was concern for their children that provided the motivation to think about changing behaviour. None stated that partners or friends had instigated an equivalent response, although some women (5: 30) alluded to the influence of witnessing the impact of their addiction on their relatives.

Carol's son was twelve years old and she explained that it had been Jason's ultimatum which had prompted her decision to ask for drug treatment. Since his mother had begun dealing heroin, he was said to have deeply resented the drug-related activity in his home. Carol said that Jason had provoked her sense of responsibility as a mother, and now that her drug use was stable, he was supportive and they had re-established their relationship. In this extract, Carol described the impact of her child's influence.

*Carol, 42 years*

*"The final straw was when Jason (son) didn't want to stay with me any more and wanted to live with his sister and Dave (stepfather). Things were getting pretty difficult for us. He objected to so many people coming to the house all the time and he was having a hard time with that."*

Other mothers had simply come to a point of reckoning the fundamental conflict between the pursuit of a drug-using lifestyle and the demands and responsibilities of childcare. Interviewees (18: 18) maintained that their

children's welfare would now take priority, and it was often said (14: 18) that this had become the talisman to persevere with drug treatment, in addition to providing the motivation to change behaviour.

*Liz, 21 years*

*"It's behind me now. In my mind it's behind me now. I know I've still got a way to go but I've got too much to lose to go back to it now. I keep Gary (son) in front of me and if it wasn't for him I wouldn't be here now. I've felt so desperate sometimes. He's my big motivation, Gary doesn't need a junkie for a mother and I owe it to him to get sorted out."*

Lara was one who spoke of a new appreciation of the more mundane aspects of motherhood, which she said had emerged as she began to overcome her dependence. She described her children as *"the greatest gift in life"* (Burns & Burns, 1988), and asserted that this gratitude motivated her commitment to *"face it"* by changing behaviour, and now to remain drug-free.

*Lara, 28 years*

*"You can hide away or face it, and for me it was the kids, realizing that they were the greatest gift in life for me, and I needed to look after that and not risk losing it. Once I felt I couldn't cope with being a mum, and now I love it. It's about getting up and seeing their little face, just things like that."*

These drug-using mothers asserted that recognition of the clash between managing an addiction and satisfactory childcare became a powerful catalyst for re-assessment of their lifestyles. Observing the impact of maternal drug misuse on children's welfare, and recognising their own dereliction of duty was said to have served as a harsh reflection of what they had become, addict mothers. It may also be argued that drug-using men may be influenced by their children's welfare in a similar way, but the main focus of this study was on the experiences of women drug users, who tend to be the primary carers. Furthermore, it has been estimated that a greater proportion of mothers (64%) remain living with their children than do drug-using fathers (37%) (ACMD, 2003; Mcier *et al*, 2004), and nearly half (8: 18) of this group were single mothers.

Many interviewees (14: 18) therefore proposed that they found it helpful to *"do it for their children"*, but admitted disappointment that relapse to addiction had occurred repeatedly despite this strategy. Total commitment and *'readiness'* (Rosenbaum & Murphy, 1984) appeared to be lacking, and one interviewee urged other women to *"do it for themselves"*, claiming that soon other aspects of their

lives might benefit too. There will be further discussion about the motivations and incentives to cease problem drug use later in this thesis.

### **Summary**

It was clearly portrayed in the women's accounts in this, as in many other studies, that interviewees' children were vulnerable to the structural factors surrounding their parents' addiction, as well as to the environmental risks of unattended needles, syringes or substances (ACMD, 2003; Barnard & McKeganey, 2003; Keen & Alison, 2001; McIntosh & McKeganey, 2002).

Parental drug use can impact upon the stability of the home, and can result in social stigmatisation, as well as family disruption and separation (ACMD, 2003). Interviewees often acknowledged that their preoccupation with heroin had been injurious to their relationship with their children (Hoffmann & Cerbone, 2002), and now declared their guilt about its detrimental impact during pregnancy, early motherhood and upon the care of older children.

Some women claimed that their ability to maintain a stable home life for their children was unaffected by heroin use, whilst others conceded that the self-involved chaos of addiction meant that undertaking the activities of daily living and children's routines was difficult. A number of interviewees said that their capacity for parenting had been disrupted by domestic abuse, and some said they knew that witnessing violence had affected their children's psychological state (Hague & Malos, 1998). It emerged that children living in homes where there was substance misuse could be exposed to additional harm from the criminality which often accompanies drug addiction: this could be from exposure to illegal activities, or as a result of separation if parents were arrested and imprisoned.

The impact of this maternal addict influence seems to be affected by the severity of her addiction and stage in her problem drug use 'career' (Sumnall *et al.*, 2006). As drug use became stabilized by treatment, some interviewees asserted that only then did the full impact of their addictive behaviour become clear to them. Interviewees often realised the burden they had placed on concerned relatives, who had taken care of children when their mother's drug use had become problematic. Mothers claimed that children's welfare, which may have been seriously jeopardized by her heroin addiction, was now of prime importance.

One aspect of this was said to be a motivation to dissuade their children from ever engaging with substances themselves.

In a few instances, mothers (3: 18) had become involved in family support projects which can help to promote positive attachment with their children, and to improve family welfare and dynamics (Dore *et al*, 1999; Russell, 2006). Banwell and colleagues (2002) note the need in this type of approach to create a balance between developing trust with families and being able to intervene if problem issues emerge. Furthermore, it has been asserted that improvements in outcomes for children from drug-using homes can also be enhanced by strengthening inter-agency collaborative working and joint training (Harbin & Murphy, 2000), and by developing information sharing protocols (McKeganey *et al*, 2002; Russell, 2006). Agencies may thus be able to improve the health and well-being of affected children by engaging in greater partnership working to enable local service development (ACMD, 2003).

Additional proposals include respite projects for children, which involve fun and play to reduce the children's isolation and stigmatisation (McKeganey *et al*, 2002), as well as drug use contracts with goals and timescales, for agencies in partnership with parents (Aldridge, 1999; McKeganey *et al*, 2002; Russell, 2006). Furthermore, it has been argued that universally accessible services, using a range of approaches, should increase provision for vulnerable children to mitigate existing harm, and to allow them to develop their full potential (Russell, 2006). Russell (2006) affirms that the welfare of children is of paramount importance, and that early support interventions are preferable in order to benefit families affected by problem drug use. A major inquiry into the needs of children of problem drug users has asserted that reducing the harm to children affected by substance misuse within their families should become a key objective for drugs policy and practice (ACMD, 2003).

Paradoxically, children were claimed to have exerted a significant influence over the pattern of their mother's heroin use, and some interviewees claimed to have modified drug use since pregnancy had been confirmed. It has been argued that the stereotype of the woman drug user portrays '*a morally weak individual, concerned about her own needs and by implication uncaring of those of her child*' (Taylor, 1993). This did not seem to be congruent with interviewees' accounts of

their attitudes to pregnancy and motherhood, and many said they tried to implement protective strategies (Kearney *et al*, 1994; Taylor, 1993), claiming that children were removed to a safer place, away from the perils of a drug-using environment. It was not possible to verify these claims in retrospect, and they may well have arisen from interviewees' desire to present a positive image in a public account (Moore & Rosenthal, 1993; Jamieson, 1998). Moreover, the women's recollections of the demands of a dependent drug-user's lifestyle invited speculation about their children's welfare, and whether it would in fact have been possible to maintain a stable home life. Nevertheless, no information which gave rise to specific concerns about children's current situation was shared with the researcher, and this was corroborated by the individuals who had sponsored the interviews.

Whatever the reality of that situation may have been, interviewees' accounts indicated that for women drug users, the responsibilities and aspirations of motherhood could provide a framework on which to build a strategy to end their problem drug use, assisted by drug treatment services. Appropriate support may help to develop the addict's personal resources, to clarify priorities and motivation, and to establish a foundation on which to address other health and social needs. Pregnancy has been described as '*a window of opportunity*' for drug treatment interventions (Chavkin, 1991), and McIntosh and McKeganey (2002) have remarked upon the important role that children can play in their parents' recovery from addiction, arguing that services should challenge parents more about the impact of their continued drug use upon their families. It has been asserted that the number of children affected by parental drug use is only likely to diminish when the number of problem drug users decreases, and that effective treatment for the parent can also benefit the child (ACMD, 2003). It is therefore imperative that drug-using parents, and their children, have access to the most appropriate treatment and support facilities and interventions.

Rosenbaum (1997) has declared that many drug-using women view pregnancy as a prime motivation to enter treatment, and it appeared from interviewees' narratives that this may have been a potent influence for the mothers in this study. The next chapter will account for the range of reasons women gave for

approaching drug treatment services, as well as their descriptions of experiences of this next stage of their drug-using '*career*'.

## **Chapter 6**

### **Treatment for addiction: Influences on help-seeking**

In this chapter, some of the key influences upon the women's decision to seek help with their addiction will be described. These factors were said to have included: the desire for normality; the persuasion of others; and a recognition and rejection of the kind of person they had become. During the course of the interviews it was clear that there were complex motives behind the women's desire to break the pattern of addiction, and consistent themes will now be considered. Interviewees recollected their fears of coming forward for assistance with their heroin use, mentioning the perceived barriers they faced and the feelings of ambivalence which often persisted. This section will begin by briefly reviewing what is currently known about women addicts and drug treatment, and it will consider the issue of unmet service needs. In this review there is no intention to make a comparison with the treatment needs of men, but to note the evidence base about women and drug treatment.

#### **Women and Drug Treatment**

Statistical data for the UK reveals that the ratio of problem drug users (PDU) in treatment is 3:1 and that this indicates an under-representation of women drug users in service provision (DH, 2000), which has remained consistent since 1996 (DH, 1997). However, a recent review challenges this assumption because of a lack of clear evidence and indicates that female PDU prevalence rates may be lower, although this could still represent under-reporting (Best & Abdulrahim, 2005). There appear to be regional variations which may confound national estimates, but which may be influenced by local service configuration (Hay *et al*, 2001).

It has also been asserted that there are age-related effects, with higher prevalence among younger women, probably influenced by increasingly earlier ages at initiation (Ziberman *et al*, 2003). Overall prevalence rates of illicit, but

not necessarily problematic, drug use in the UK indicate that women form between one quarter and one third of the drug-misusing population (Singleton *et al*, 2001), and that this replicates world-wide estimates (Hepburn, 2002). In the North West Region, clear age differences were demonstrated in both the use of treatment services and needle-syringe exchanges, with younger women presenting in increasing numbers: it was also found that women tended to have shorter drug-using careers before seeking treatment (Beynon *et al*, 2001). Other researchers have corroborated the finding of earlier help-seeking (Anglin *et al*, 1987; Hser *et al*, 1987; McCance-Katz *et al*, 1999) and have pointed out that women develop health problems sooner (Lex, 1991; Powis *et al*, 1996), and often remain addicted for longer (Anglin *et al*, 1997; Hser *et al*, 1987) which in many cases may be linked with their partner's drug use (Powis *et al*, 1996), as well as issues of psychological co-morbidity (Swift *et al*, 1996).

Women drug users have been said to experience higher levels of mental health problems, including low self-esteem, anxiety, depression and attempted suicide (Becker & Duffy, 2002; Gilbert *et al*, 2001). Green and colleagues (2002) have noted that women on low income with more mental health conditions are significantly less likely to initiate treatment, or to return after first assessment. Green and colleagues (2002) go on to argue that competing role expectations, such as childcare can interact with co-morbidity to deter treatment initiation and completion. Perhaps significantly, the observation that fewer women approach treatment services sits in contrast with women's use of other healthcare services, where they have been shown to request more medical care (Green & Pope, 1999).

Furthermore, Ettorre (1992) has asserted that women who misuse drugs may be seen to be '*polluted*' and to have breached society's code of acceptable female behaviour. One consequence of this is limitation in their choice of sexual partners to men who are already drug users (Gossop *et al*, 1994; Klee, 1993; McKeganey & Barnard, 1992; Powis *et al*, 1996), and it has been said that drug use and dependence inevitably escalates (Almog *et al*, 1993; Hser *et al*, 1987; Klee, 1996; Rosenbaum, 1981a). It has been noted that women are more likely to be living with a drug-using partner (Davies, *et al*, 1996; Gossop *et al*, 1994; McKeganey & Barnard, 1992), and do less well in treatment if he is not supportive (Eldred & Washington, 1976). A cross-cutting theme appears to be

that women drug users typically experience poverty, illegality and marginalisation in their everyday lives (Carlson, 1996).

Hickman and colleagues (2004) have examined gender differences in PDU attending: needle-syringe exchanges; drug treatment services; and Accident and Emergency departments; and they also included a community-recruited sample. Although they found age-related differences in their study, they declared that women's representation in treatment replicated prevalence. Recently, it has been argued that while the presenting characteristics differ between the genders, and women's needs may still not be adequately addressed, there may even be over-representation (Best & Abdulrahim, 2005). Best and Abdulrahim (2005) argue that prevalence of female problematic drug use appears to be lower, but they acknowledge the need for more robust datasets.

Nevertheless, feminist researchers have repeatedly called for gender differences to be recognised in treatment settings (Abbott, 1994; Ettorre, 1989, 1992, 1994). This may equally indicate that there is a need not only for services which better meet women's needs, but are also tailored to gender-specific needs for the majority population of male drug users. Since this study was concerned with the influences upon a sample of women drug users, the next section will now account for some of the literature which has discussed the need for female gender-specific drug treatment.

### **Gender-specific treatment services**

It has often been asserted that female drug-users have different treatment needs from their male counterparts (Becker & Duffy, 2002; Ettorre, 1992, 1994; Hartnoll, 1992). The aetiology of women's drug use has been reported to be at variance from men's (Greenfield *et al*, 2003; Najavits *et al*, 1997; Neaigus *et al*, 2001) and appears to present more frequent issues of victimisation (Becker & Duffy, 2002; Bennett & Lawson, 1994; Blume, 1990; Copeland & Hall, 1992; Hien & Scheier, 1996; Root, 1989; Swift *et al*, 1996), past trauma (El Bassel *et al*, 2000; Gilbert *et al*, 2001; Horgan *et al*, 1998; Najavits *et al*, 1997; Root, 1989), and family or interpersonal difficulties (Holsten, 1985; Kosten *et al*, 1985; Robbins, 1989). Many women attending drug agencies are said to present a range of concomitant problems such as self-harm or parasuicide; personality and eating disorders, or psychological distress linked with depression, anxiety

and affective disorders, (Becker & Duffy, 2002; Blume, 1990; Boyd, 1993; Copeland & Hall, 1992; Reed 1985; Robbins, 1989; Ross *et al*, 1988; Swift *et al*, 1996; Underhill, 1986; Weaver *et al*, 2004), and it has been argued that unless these are effectively treated outcomes will be poorer (Becker & Duffy, 2002; Blume, 1990; Boyd, 1993).

Some commentators argue that women are less likely to present to services (Glanz & Taylor, 1986; Oppenheimer, 1994; Sheehan *et al*, 1988). The reasons for lower attendance rates have often been linked with childcare responsibilities (Copeland & Hall, 1992; Fraser, 1997; Kline, 1996; Reed, 1987), and the male-orientated culture of many treatment agencies (Abbott, 1994; Copeland & Hall, 1992; Marsh & Simpson, 1986; Murphy & Rosenbaum, 1999; Powis *et al*, 1996; Stewart *et al*, 2003; Waterson & Ettorre, 1989). At particular risk of invisibility from services are women with more severe mental health problems or those from minority ethnic communities (Becker & Duffy, 2002). A substantial barrier for many mothers appears to be the threat of professional intervention and the forced removal of their children into local authority care (Ettorre, 1992; Klee & Jackson, 1998; Kline, 1996; Marsh *et al*, 2000; Oppenheimer, 1994; Powis *et al*, 2000; Taylor, 1993; Vitellone, 2003). In addition, the stigma accorded to female substance misuse seems to persist and many women fear public disapproval and humiliation (Barnard, 1993; Lex, 1991; Perry, 1979; Robbins, 1989; Rosenbaum, 1981a; Swift & Copeland, 1996; Underhill, 1986; Taylor, 1993), as well as lack of confidentiality (NTA, 2002). It has been found that a greater proportion of women share their injecting equipment with their partners and often rely on them to secure supplies from services, to avoid identifying themselves as IDU (Barnard, 1993; Dwyer, 1994; Powis *et al* 1996).

It has often been argued that women's treatment needs have not been adequately considered or met (Copeland & Hall, 1992; Ettorre, 1994; Hartnoll, 1992), although recent service reviews have begun to address this deficit (Becker & Duffy, 2002; Neale, 2004; NTA, 2002). Becker and Duffy's (2002) review of available research aimed to identify any barriers and gaps in provision for women drug users and used literature review, followed by a case study approach, to identify good practice in engaging and retaining female clients. These researchers also examined the challenges faced by drug agencies in trying to attract and retain women clients, and used their findings to recommend

service development. In order to engage more women, they suggested a range of outreach services; help with travel and childcare; and due consideration of the effects of male victimisation on women's participation in mixed-sex groups. In order to retain more women in treatment, they advised a client-centred and needs-led approach, which considered women's drug use in the context of the many other problem areas of their lives. This was complemented by the treatment framework, *Models of Care for the treatment of adult drug misusers* (NTA, 2002) which highlighted women drug users as a 'special group', by identifying their specific treatment needs. This guidance gave recommendations on how services could be improved to better meet them, for example by ensuring that comprehensive healthcare provision was also integrated with social care, criminal justice and mental health services. *Models of Care for the treatment of adult drug misusers* (NTA, 2002) confirmed the need for women's services to take account of concomitant issues of mental health, which was said to be often linked with physical or sexual abuse and eating disorders. Further to these documents, Neale (2004) conducted an analysis of the differences between men and women beginning new episodes of drug treatment in Scotland. She found that there did appear to be a range of distinct gender variations, but that there were also many commonalities in the drug users' experiences of addiction and need for therapeutic interventions. A key recommendation for practice was that assessment for treatment should be gender-sensitive, but that drug users of either gender should be seen as individuals, in a manner which avoided stereotyping.

The content and outcome of treatment programmes do seem to show gender variations (Powis *et al*, 1996), but there appears to be some evidence that women can often succeed in recovering from addiction (Holsten, 1985; Hser *et al*, 1987; Wright & Klee, 2000). Commentators have asserted that services which offer some kind of childcare provision often have better retention rates for female drug users (Marsh *et al*, 2000; Reckman *et al*, 1984; Reed, 1987). Furthermore, thorough assessment of women's psychological state has been advocated to enhance the likelihood of successful outcomes (Blume, 1990; Boyd, 1993). It has also been said that the social context of female drug users' lives must be recognised and issues such as acceptable appointment times (Fraser, 1997) and support with developing social networks (Finkelstein, 1996), as well as relationships with partners (Finkelstein, 1996; Lex, 1993) can assist towards

recovery from addiction. Powis (1995) has argued that it is essential to understand the influence of male partners upon female drug use in order to offer treatment which is both effective and attractive. It is also imperative to remember that women drug users are not a homogeneous group and that there are also differences between women which may affect their experience of substance misuse and treatment services, based upon age, sexual orientation, ethnicity or disability (Ettorre, 1994; Roberts *et al*, 2000).

### **Drug treatment provision in North Cumbria**

At the time of this study, local data indicated 509 problem drug users in contact with treatment services in North Cumbria (Cumbria DAT, 2004). Less than one third of these were female and this proportion is consistent with national figures which are believed to indicate under-representation, since patterns of male and female drug use seem to be converging (Becker & Duffy, 2002; DH, 2000; EMCDDA, 2005). The National Drug Treatment Monitoring System (NDMTS) has recently estimated the proportion of female drug users to be up to 28.24% across the North West Region, but in Cumbria it was suggested that this could now be as much as 32.71% (Khundakar *et al*, 2006). Local treatment services include: structured counselling and day care; community prescribing; needle-syringe exchange; and limited inpatient detoxification and residential rehabilitation facilities. Statistics from the local needle-syringe exchange services suggest a client ratio of 3:1, but age-band data is not currently available (NCABS, personal communication, 2005). The pharmacy-based scheme is only available in the larger towns, and Neale (1998a) has pointed out that the need to travel to services can discourage many IDU, and that women in particular fear any indiscretion.

### **Influences on interviewees' motivation to seek help with addiction**

When considering whether to undertake drug treatment, it seems that both male and female drug users portray concerns about regaining control of their lives (Copeland & Hall, 1992; Taylor, 1993; Wright & Klee, 2000), but Wright (2002) suggests that women may interpret this more widely, to incorporate issues such as personal relationships, dealing with domestic violence or guiding their partner towards treatment (Fraser, 1997). Kline (1996) has advanced a view that while men often sought treatment because of fear of drug-related violence, women raised issues of psychological distress, relationship problems and concern for

their children. Rosenbaum (1981a) also points out that although denial of problematic use is not exclusive to women, they may jeopardise more by seeking help than men in similar circumstances, because of associated stigma and public censure.

It has been asserted that recognition of the problem, interpretation and evaluation of its severity are important components of the motivation for any change in behaviour (Murphy & Bentall, 1992). In their research into the process of recovery from addiction, McIntosh and McKegancy (2000) have signalled the importance of the drug user's interpretation of 'self' and realisation of the way in which this '*spoiled identity*' (Goffman, 1963) has been affected. They have argued that recognition of despised drug-related personal characteristics, which are also unacceptable to those close to them, may prompt the addict to seek help to change behaviour. Particular events, for example, pregnancy, or a range of external factors may highlight the unwelcome consequences of drug dependence. McIntosh and McKegancy (2002) have developed this assertion by arguing that a successful recovery will most probably be associated with the addict's desire to restore self-concept, which will also require feelings of self-efficacy, and a belief a drug-free life may bring improved circumstances.

Throughout their accounts, as interviewees described their hopes and aspirations for drug treatment, it became clear that there was some variation in their use of the term 'recovery'. This appeared to sit on a continuum from: abstaining from the use of heroin; to using prescribed substitute medication but not heroin; to having stabilised their chaotic and sometimes criminal lifestyle but occasionally or regularly still using illicit drugs. This study was framed around describing the influences on women's drug use in North Cumbria, and it is interviewees' notion of what 'recovery' meant to them which is presented in this thesis. It was evident that for some interviewees, taking control of their chaotic drug-user lifestyle was in itself a success in their terms. There was no intention to define 'recovery' from a professional or clinical perspective, and the judgement of what that meant is orientated towards the women's ideas about treatment, and lies within their narratives rather than the casting of 'recovery' by the researcher.

Interviewees presented a raft of motives which they said had influenced their decision to relinquish heroin use. These included: becoming "*tired of the hassles*" attached to supporting a drug habit; needing to "*take control*", regain self-respect and a "*normal*" life; renewed awareness of the risks; contact with the criminal justice system; or to use methadone to extend their heroin supply. These factors were strongly underscored by the influence of '*significant others*': their families of origin; sometimes sexual partners and for those who were mothers, because they said they were appalled by the effect of their addiction upon their children. These stimuli were not mutually exclusive, but consistent themes will now be reviewed.

### **The desire to regain a "*normal*" life**

The concept of drug use as a '*career*' for female IDU (Rosenbaum, 1981a; Taylor, 1993) has already been considered, and refers to the process of learning to become a drug user and developing necessary skills to perform the required routine tasks. When reflecting on this stage of addiction, interviewees often alluded to "*becoming tired of the routine*" and needing "*to take a break*" and retire from the effort needed to finance and procure heroin on a daily basis, as well as maintain the business acumen needed to manage a dealership. Cindy described the overwhelming demands and dangers of this regular pattern.

#### *Cindy, 17 years*

*"We were going down to Liverpool in his (partner) brother's car every three days and bringing it back. And that was a lot of money. I mean a lot of money. Very, very scary. We went to some very dodgy places, men with guns, I was terrified really. We didn't get caught, but we'd had enough."*

None of the women in this study indicated that their desire to end their addiction emanated from the substance itself, rather it was with external circumstances linked with a heroin user's lifestyle. Nevertheless they frequently commented (26: 30) on the way in which heroin's pharmacological and physiological effects changed as dependence increased and they used heroin simply to feel "*normal*", since they no longer derived pleasure from the euphoria. Tolerance is a physiological process whereby the body adapts to the effects of opiates so that increasing amounts are required for satisfaction. On the other hand, dependence occurs when the user needs the drug to feel normal and withdrawal symptoms are experienced if the supply is disrupted. Interviewees had perceived this pressing need as one of the first indicators that drug use had become

problematic and that change would eventually be required (Prins, 1995; Stimson & Oppenheimer, 1982).

*Cindy, 17 years*

*"It got to the stage when I was taking heroin and it wasn't doing anything for me. It was just to keep us straight. And that got boring. And the supply dried up for a while round here, and I was having to take a taxi to where I could get hold of it. And it was all such a lot of money to get and to get it. £25 each way. I was spending £1000 in three days, a lot of money and a lot of time."*

Other interviewees (16: 30) reflected on the long-term impact of acquiring the substantial amount of money needed to buy heroin to feel "normal" and said that realising the futility of this expenditure had reinforced their need for change.

A consistent theme (24: 30) was the women's motivation to fulfil normal aspirations for everyday life, similar to those of their non-drug-using counterparts. On the other hand, Jo reserved doubts about the possibility of re-entering conventional life, and was aware that challenges that might lie ahead. She went on to provide an example of her perspective in the following extract.

*Jo, 30 years*

*"To be normal, that's the main thing. Little house, car in the drive, go to work every day, odd weekend out, just be normal. When you start on heroin, all the doors in life just close. Once you're on it, you just can't do normal things. You don't value that until you've lost it (laughs). Once you've been on heroin, life will never be the same again."*

Central to the aspiration to become drug-free for most women (21: 30) was the need for financial independence and a different 'career' to confer status and some purpose for their days. Some women (9: 30) confided that they lacked basic skills in literacy and numeracy, often as a result of disrupted education, truancy or other barriers to learning, and this could present a formidable deterrent to gaining employment. Any opportunity to redress this lack was highly valued, as Jo added, "a second chance and not to be wasted": this skills training had often been facilitated by treatment agencies, or was a component of criminal justice intervention programmes.

### **The impact of contact with the Criminal Justice System**

A custodial sentence was said (3: 6) to have been a powerful deterrent to recidivism for at least half of those interviewees who had ever been imprisoned (6: 30), as well as a stimulus for compliance with treatment and Moira was

amongst those who had experienced catharsis. She went on to describe the impact of being imprisoned on her motivation to try to quit heroin use.

*Moir, 40 years*

*"When I was in prison, I was just put in a cell in the hospital wing. I had a really bad time with the withdrawals and everything. And though it was very bad, in some ways I think it was a good thing because it made me think twice about going back to it. I hated prison. When the prison officer took me to the gate for the last time, she said, 'Moir, I don't think I'll be seeing you again. I've been here 20 years, and I can usually tell the ones that'll bounce back in'. It was awful, being away from my family and Jeannie(daughter) was only small. Terrible. Prison was the best thing that could have happened to me then."*

Nevertheless, prison was not seen to be a deterrent for everyone, and Pauline said that for her a custodial sentence became an opportunity to gain respite from the lifestyle and something she tried "to arrange" when she needed a "rest".

*Pauline, 39 years*

*"I even asked if I could go to prison. That time I went out on purpose to get caught, just to get a break from it all, get out of it, a rest. All of it, the family, Johnny, all the drug business. All of it. Three months in jail. I enjoyed it. It was great. I was looked after and it was a break. It sounds daft, doesn't it?"*

### **The desire to extend supplies of heroin**

Some women (7: 30) admitted that an underlying motive for seeking treatment was to acquire a regular prescription for methadone, which would enable them to continue using heroin, but with fewer withdrawal discomforts when it became scarce for any reason. Connors (1992b) found that addicts often described their lives through accounts of pain, and a few interviewees said they used methadone prescriptions as a strategy to mitigate the effects of withdrawal, while retaining some of the heroin experience, even if this was only drowsiness. Most (21: 30) but certainly not all women admitted having engaged in some type of criminal activity to fund their habit: it has been pointed out that by supplementing heroin with prescribed medication addicts can also reduce the risk of arrest (Rosenbaum, 1981a).

Some interviewees (6: 28) were aware that addict partners had encouraged them to come to the treatment agency for a prescription, so that they could experience intoxication by using methadone and thus a lesser amount of heroin, but they did not believe that this suggestion had been for their personal benefit. Linda was one who believed that a similar strategy for seeking a prescription was

employed by a significant number of local addicts. She described her own views on the motivation and intentions of other drug users, and may be seen to have claimed the moral high ground in this next instance.

*Linda, 23 years*

*"80% of them will go for Subutex and get a gouch off that. A lot of them do it for the extra hit to top themselves up and don't really intend to come off because they don't think they can. But I'll be honest with you, there are only a few who've actually come properly clean in this town, people that were right down in the gutter like me."*

Another interviewee said she felt strongly that individuals pursuing this course of action were simply not worthy of treatment, and indicated that there was a difference between those receiving public assistance. Becky was forthright in her views, evoking the ethos of nineteenth century Poor Laws, with distinction made between those who may be 'deserving' of support.

*Becky, 22 years*

*"Some people come for two reasons: to tide their heroin over when they've got no money; or to sell their tablets to buy heroin. At the end of the day I'm the same as any other tax-payer. I know it's a bit hypocritical, because I'm sat here myself, but my view is, the people that want help and want to help themselves should get it and the others, they're just a waste of space. It's not right to pay for them at all."*

In addition to these motives, interviewees spoke about the influences that their own families, and particularly their children, but seldom partners, could exert upon this stage of their drug-using 'career', when the women were 'ambivalent' and beginning to consider treatment for their problem drug use (Rosenbaum, 1981a). This section will now account for the influence of 'significant others' on help-seeking for problem drug use.

### **The influence of 'significant others' upon help-seeking**

#### **A partner's influence on help-seeking**

It was notable that women rarely (2: 28) spoke of their partners having a direct role in encouraging them to seek treatment for their own well-being. However, many interviewees (22: 28) mentioned the dilemma that faced them when considering quitting heroin, because both its use and the associated lifestyle

were closely linked with their sexual partner. A few addict couples decided to seek help together (6: 28) but most women did so separately (22: 28); sometimes to economise on heroin (6: 28); and a few women (4: 28) said that they had influenced their partners to quit. Notably, a couple of interviewees were convinced that having a boyfriend (a non-drug-user) for the first time provided the impetus to cease heroin use. In one case, the boyfriend later discovered she was a heroin addict, but the other man remained unaware that his partner was drug-dependent.

Jeannie was one of the few who linked the decision to come forward for treatment with her former partner, but this influence was indirect. She tearfully remembered her boyfriend's sudden death, and this shock was compounded soon after by the death of her next partner from a deep vein thrombosis.

*Jeannie, 23 years*

*"Because he (previous partner) just came out of jail and had a hit and went over. I really liked that lad, that really hit me. I realized how close it was to you, and that was when I went for help. I'd been using for quite a bit and I was devastated. I realized how everybody, everything was going downhill, cracking up around us. My partner (current) came along, too. He was my children's father, and he was a user as well. In fact, he just died last January just gone. It was a blood clot, and they said it was drugs that caused it. But I left him to get my life back, because of my kids, everything. Everything was falling to bits, and I needed to get out of that whole drugs scene. So I took the kids and came home to Mum's, here, and now I don't want to go back."*

### **Ambivalence about continued heroin use**

Some of the women (6: 30) explained that the process of deliberating the decisional balance about heroin use was tinged with ambivalence, which affected their motivation to commit to behaviour change. Lisa admitted some anxiety that heroin addiction was not only associated with the pharmacological effect of the substance itself, but that using it had psychological and emotional components. The absence of the functional effects of heroin, which were often described as *"warmth and feeling safe"*, *"being wrapped up in cotton wool"* or *"feeling loved and wanted"* also led to concerns about an equivalent replacement.

*Lisa, 23 years*

*"I don't know, really. But just the thought of not having anything, just a bit scared of having nothing at all. I didn't think I could manage. It's hard to imagine what life will be like without something, that's the worst bit of dependence."*

Another source of apprehension for some interviewees (8: 28) was the thought of coping with a drug-free life, because of the determinant role which they said that heroin played within their relationships (Rhodes & Quirk, 1998). The meaning of a shared drug addiction was not hidden and women expressed concern and sometimes asked for reassurance about the stability of their liaisons once they became drug-free. Nevertheless, Gemma maintained that in addition to their shared addiction, there was a strong bond of affection within her marriage.

*Gemma, 28 years*

*"And well I'll still love him for the person he (husband) is and how he looks after me. It was the heroin that drew us together in a way - I suppose when we were both using it kept us together for what it does. I certainly ended up using more when I started going with him - it was what drew us together, yes, but I hope we'll still be together for what we are to each other. I'd like to know if we'll be alright."*

### **The influence of families upon help-seeking**

Interviewees often spoke about the way that worried families could motivate them to ask for help with their drug problem. The concerns held by relatives were said to have included: anxiety about a daughter or sister's appearance and welfare; or the impact of addiction on the health and well-being of parents or other kin; and the perceived public humiliation and disgrace for the family itself

#### **Interviewees' relatives' concerns**

It appeared that families, and interviewees' mothers (16: 30) in particular, were a strong influence on the decision to approach treatment agencies (Donoghoe *et al*, 1987). This anxiety was often prompted by the dramatic change in their daughter's personal appearance, resulting from the self-neglect often associated with heroin use, and women acknowledged this as a source of parental distress.

*Sharon, 22 years*

*"But I was so skinny, my eyes all black and sunken, and my face all drawn in when I was deep in it. Teeth all broken to bits. You really need your family. You need that support. My mam made me go to the doctor."*

Some anxious families had eventually had to set boundaries, after a series of broken promises and betrayals of trust. Several women (14: 30) spoke of a gradual process of realising they needed help, but Elaine recalled that moment

when she knew that drug use must cease. Her personal nadir came one Christmas, often a time of family reunion and celebration, but for Elaine, in wretched circumstances and isolated from family and friends, the poignancy of the situation was intense. She spoke of her despair that heroin addiction had resulted in destitution, and said that full recognition of the impact of rejection by her family had motivated her to seek treatment.

*Elaine, 24 years*

*"That last Christmas, that's what really decided me that it finally had to stop. I've never been so low like that in my life. Mum and Dad wouldn't have anything to do with me, none of the family - it was just a nightmare. Begging in the streets, porridge for dinner, and getting arrested all the time. Pinching food, feeling ill all the time, it felt like it was a slow death."*

On the other hand, some interviewees remarked that family members blamed them for a parent or other relative's ill-health, and even their death. A few women (3: 30) said that they had been profoundly affected by the death of a parent, knowing that their own drug use had been a disappointment and that there was now no possibility of redemption. Linda's three siblings were all drug users, but she believed that her own addiction had been the greatest blow. She was convinced that her father's death had consolidated her own motivation to seek help for her addiction.

*Linda, 23 years*

*"It's been a very hard, hard battle to get the will to want to come off it. When you're right down there and you're in such a way that you can't even be bothered to have a shower, brush your hair, clean your teeth, you don't care no more. I had to pick myself up from all that. My dad was alive then and I was my dad's babby. I broke his heart. He never expected to see it from me. (Tears) He should have told us, should have told us, and I would have got myself clean straight away, he didn't have to die. He chose to take those tablets. But I had to work to get the will to get out of it. The will was there anyways, but once my dad died, that was the shock that really kick-started me to getting off."*

Sometimes the death involved was heroin-related and several women (12: 30) spoke with sadness of the loss of siblings and cousins. It was denied that these deaths became a deterrent, but it had often served to signal the accumulation of risks attached to the use of drugs, as well as interviewees' own proximity to serious harm.

Women continually remarked that the costs attached to being a drug user had made them question the appeal of, and their commitment to, the heroin-using lifestyle. One specific cost faced by mothers was said to be losing custody of their children, if their drug use came to the attention of statutory authorities. Even if public care was not implemented, a mother's drug use could often provoke friction when grandparents had concerns about the welfare of young children and the mother's capability for childcare. It was reported that many of the addict mothers' own parents (8: 18) took over the care of young children, either informally or with statutory approval, sometimes just when drug use was chaotic, but for others this lasted until adolescence. Interviewees (14: 18) said they had recognised with guilt, the physical, emotional and financial burden they had placed on caring relatives and that this became a strong motivation to seek help.

### **The shame of public disgrace**

Many interviewees (16: 30) proposed that local environmental influences could affect help-seeking, claiming that they had feared indiscretion about their drug use, and declaring that *"here everyone knows your business"*. It may equally be found that similar concerns will deter addicts in other locations, but Henderson (1998) has noted the *'higher visibility'* of individuals in non-urban communities and its subsequent impact on delayed presentation for the treatment of drug problems.

Some women (8: 30) believed that this public disgrace was particularly painful for their families, and they had become conscious of the *'spoiled identity'* of their families of origin. This may be a result of this *'higher visibility'* within non-urban settings (Henderson, 1998; Jamieson, 1998; Mentor UK, 2004), but families of city-based drug users may have an equivalent experience. Interviewees frequently spoke with remorse and distress that their drug use had disgraced their parents since they had come from a *"good family"* who were now subject to public scrutiny and opprobrium.

In the following extract, Kirsty reflected upon her *"previous self"*, and described having a respectable job and good social and family life, which she had lost when she became an addict. She declared that she was now disgusted with her actions and behaviours as part of her heroin-user lifestyle, and now wanted to

dissociate herself from that identity. This resonates with previously mentioned research into the process of recovery from addiction (McIntosh & McKeganey, 2002). She was particularly sorry for the disgrace felt by her family, whom she said found it difficult to accommodate this public humiliation, which was apparently often increased by lurid media reports.

*Kirsty 22 years*

*"Lost my job, I just stopped going. I worked up at the big Garage, quite a good job, and I'd been to College and everything. Lost my own friends, even lost my family for a bit, lost three years of my life. It's always there, they fetch it up all the time. I've done thefts, been to Court, my name all over the papers, that sort of thing. Oh, it was terrible, especially for my family. They were devastated. But at the time, I really wasn't bothered. The heroin gets you that way, you feel nothing else can touch you. Friends just drifted away, and it was my fault really. I just focussed on him (partner) and didn't contact them, didn't phone anybody. If you're a heroin addict you do things you wouldn't dream of if you were normal and I couldn't live with myself. Heroin drives you into things – how low, how desperate you get. I was ashamed to think of what I'd become."*

It has been argued that drug-using mothers are often particularly stigmatised (Taylor, 1993), most of all when pregnant (Campbell, 1999; Rosenbaum & Murphy, 1999). Connors (1990: 42) has asserted that *'the ultimate sanction that a woman may face in the context of drug use is the loss of her child'*. This fear of being parted from children, as well as other influences that interviewees' children were said to have exerted upon their mothers' help-seeking, will now be described. A few women (4: 18) said that their husbands or partners were equally concerned about losing custody of their children. The question of how this anxiety might affect male drug users remains, since the purpose of this study was to account for the influences on this sample of women drug users.

### **The influence of children upon help-seeking**

In this study, all of the mothers (18: 18) asserted that concern about their children's welfare had exerted an influence upon them to end their addiction, and this has often been noted elsewhere (McIntosh & McKeganey, 2002; Rosenbaum, 1981a; Taylor, 1993). There were frequent comments of for example: *"getting my life back together for the two little ones"*; *"he's my lifeline"*, *"I wouldn't be here without him"*; or *"I didn't want my kids to suffer no more"*. These concerns may also be expressed by men who are drug-using fathers, and this factor may provide an opportunity for therapeutic professionals to

encourage addicts of either gender to consider the impact on their children of continued heroin use (McIntosh & McKeganey, 2002).

Several interviewees (9: 18) spoke of their concern, as has been noted elsewhere, that drug use had tarnished their image as mothers (Broom & Stevens, 1991), and said they needed to protect small children from that knowledge. Women drug users are often said to have rejected their feminine roles as women, wives and mothers (Ettorre, 1994; Malloch, 1999), and Ettorre (1992: 76) suggests the term '*polluted*' or '*spoiled*'. Ettorre (1989: 105) has asserted that addiction is even more vilified in women and that '*In private they are viewed as potentially sexless, bad mothers, uncaring for their children or irresponsible wives not considering the needs of their husbands. In public they are viewed as unforgivably out of control in their domestic or work situations, fallen angels, evil sluts, or loose women who cannot be trusted and should be avoided*'.

According to the women's narratives, recognition of any adverse effects on children's welfare became a powerful reflection of their mothers' divergence from the accepted norm, and of their '*spoiled identity*' (McIntosh & McKeganey, 2002). Linda was one who admitted that her young children had been exposed to harm from the criminality and violence which often surrounds illicit drug use, and was now disgusted by her own dereliction of duty and failure to protect them, because heroin had assumed priority. This image of an addict mother was now disconcerting, and epitomised a need for intervention with her problem drug use.

*Linda, 23 years*

*"My kids know exactly what I've done, where and what. They've opened the door and everything's been there, and the house burgled and smashed up. My daughter begged me not to do it any more. 'We'll stop your pain, Mummy'. It broke my heart to think of it – terrible things." (tears)*

Reflection on her own neglected responsibilities as a parent, was said to have been the prompt for another mother when she recalled a serious reaction to contaminated heroin. Ellie claimed that it was this incident that motivated her help-seeking and accounts for her emotions in the next extract.

*Ellie, 23 years*

*"They told me I'd had very serious internal bleeding and could easily have died. I think that really woke me up to what I was doing to me, but most of all to Nicky*

*(son). I thought 'Oh my God, If I die now Nicky won't even remember me'. I realized properly how irresponsible I'd been and so unfair. I felt very, very guilty."*

In addition, many mothers (10: 18) expressed remorse about the substantial amount of money that had been absorbed by funding their heroin use, and the necessities and treats which were consequently and constantly denied to their children.

A few women (4: 18) paid, in their view, the ultimate price for their addiction and children were removed into public care, due to concerns about drug dealing in the home or domestic abuse. Interviewees often said that this removal of children could distil the mother's motivation to commit to drug treatment, and to try to regain their care. Lara remembered an incident at a case conference when advocacy by the manager of a children's charity provided the necessary incentive and feelings of self-efficacy for her to persevere with treatment. In this extract, she recalled that it was recognition of herself as an addict mother of a newborn that was the initial prompt for her help-seeking, and she believed that with additional support she has managed to achieve her goal.

*Lara, 28 years*

*"One person kept trying to put us down there, a schoolteacher, and Roger (manager of a social care agency) stood up and said, 'Look, hang on a minute - last year none of us thought Lara was going to pull it off, and all credit to her, she's done it. How can you say that she's not capable - she's proved us all wrong.' That gave me the spur to show them I could do even more. I'll have a smart house and everything nice. When I came off heroin I moved on in myself. I knew nothing else could beat me again. But it's baby Alice that I have to thank for that - making me see what I'd become."*

All of the mothers mentioned inconsistent messages and practices between and within agencies and many interviewees remarked (20: 30) that fear of children's removal could actually discourage addict mothers from contacting treatment agencies. In the following extract, Michelle described her repeated attempts to gain the courage to approach her family doctor about her addiction.

*Michelle, 25 years*

*"I was scared coming up to the surgery about coming off - that they'd be taken away. I couldn't bear that - they're everything to me, to us both. I had a few goes, terrified, but finally got here and it was OK - I haven't seen Social Services, Health Visitor or anything, not since Emma was two anyway."*

Michelle was one of many women, mothers or not, who mentioned that fears of losing custody of children could become a barrier to help-seeking, but conversely concern about the effects of their addiction upon young families was often said (16: 18) to be an important stimulus to seek treatment. Interviewees (20: 30) frequently remarked upon their perceptions of the complex influences of children on their mothers' desire for drug treatment.

### **The influence of self-concept**

Despite this plethora of reasons for quitting heroin use, a few women (5: 30) conceded that although many of the fore-mentioned motives were important signals of the damage caused by heroin addiction, another stimulus to seek help was even more important. These interviewees had become aware, that the greatest incentive lay within themselves, their *self-concept*, and in their own desire to restore their '*spoiled identity*' (McIntosh & McKeganey, 2002). It appeared that this was rarely an immediate insight, but was usually hard-won from a disappointing cycle of relapse and renewed attempts at treatment. These interviewees were adamant that it was insufficient to cease heroin use for anyone but their own sense of self, and that this should be the real motivation for help-seeking. In the following extract, Nina described her own experience and summed up her ideas about the most effective incentive to quit problem drug use, as well as her perceptions of the value of *self-concept*.

*Nina, 27 years*

*"But there's just something about it all that's really hard to let go. Doctors can only help so much. It has to be from inside you. I've tried giving up for everyone, for my son, for my parents but it's not enough, the stuff's too strong. I know I've got to hang in and do it for myself instead of chucking it all away. I was feeling like low life really and I nearly didn't stick with it. But I've got to keep going. I know the difference in myself. Last year I was clean, and I felt great with myself. This year I'm using again, and I'm like rubbish. I look at some of my old friends with their nice families and nice homes and me, 27 years old today and I've got nowt."*

Another interviewee, Lara, who believed that she had now overcome her heroin addiction, intimated that in her experience drug users needed reassurance of their self-efficacy when they come to agencies asking for help, and to believe that recovery from addiction was possible. It has been asserted that the optimism and understanding with which drug users are received into treatment can be influential on outcomes (Ashton & Witton, 2004), and Lara recommended that

helping agencies note the importance of offering hope that shared goals were achievable. In this extract she explained the effect of relevant support and reassurance received from her drug worker.

*Lara, 28 years*

*"Sam, (drug worker), was wonderful for me. I could go into the room and he'd stand there and he'd give us a big hug, and that was all I needed. I needed my mum to give us a big hug, but that never happened. I think with all the carryon at home (domestic abuse) I just needed someone to say, it's going to be all right - you can do it. I got comfort and started to get my confidence back. I could sit and cry and get it all off my chest. I've got a bad background, you see, it's all in my family."*

### **Summary**

This chapter has reviewed the influences which interviewees described about the time when they came forward for help with their addiction. It has considered what interviewees said about becoming tired of the heroin lifestyle; desiring a "normal" life; and of fearing a number of risks, including custodial sentences, as well as losing the right to care for their children. Mothers in particular, and other family members, were often said to have persuaded interviewees to seek help. Underscoring all of these factors it was revealed that the devastating effects of their addiction on their families of origin, and the shame they claimed about the adverse effects upon their children, alerted the women to the increasingly problematic nature of their drug use. The plight of 'significant others' served as a disconcerting reminder of interviewees' status as addicts, and the women remarked that this label no longer appealed to them.

Several interviewees mentioned the barriers to help-seeking, some of which were said to derive from unease about confidentiality in non-urban communities, but it must be acknowledged that similar issues could also prevail for addicts elsewhere. Women who were mothers were said to be particularly cautious in their approach to helping agencies, conscious that their drug dependence had the potential to raise alarm about their capacity to care for their children. In some cases, it is probable that this would be well-founded, since many women described a chaotic self-involved addict lifestyle, when drug misuse was at its most problematic.

A number of women described ambivalence at this time, both about the substance itself and heroin's close link with their sexual relationships: for many women a decision eventually had to be made to separate from their male addict partners. Nevertheless, some of these women soon established new liaisons with male addicts from their drug-using social circle. However, a few interviewees said they had now overcome ambivalence, and had developed some insight into repairing the damage to their *"sense of self"*. These women often spoke of becoming tired of *"a person I no longer wanted to be"*, and said that they hoped they were beginning to move on to a new stage in their drug-using 'career'.

The next chapter will now account for the women's experiences of drug treatment services, and will also include some suggestions for service development which interviewees frequently mentioned.

## **Chapter 7**

### **Treatment for addiction: Influences and interviewees' experiences**

Interviewees were willing to talk about their experiences of drug treatment and services, as well as any influences on the progress of this stage of their drug-using 'career'. Consistent themes that were raised included: access to treatment; the length of waiting lists; choice of drug treatment; problems associated with taking prescribed heroin substitutes; and the need for support with a range of personal issues. It seemed that relapse was a common feature of this stage, and some women shared ideas for prevention, often linking this disappointment with some of the factors which they said had underpinned their drug dependence. Some women had gained insight from a recurrent pattern of relapse, and proposed ideas for interventions to enhance treatment programmes in North Cumbria. Many interviewees articulated a desire, once recovered, to help other drug users to quit heroin use, in the belief that their own authentic experience would offer credible guidance.

This chapter will now account for interviewees' experiences and opinions, and it will begin by reviewing current approaches to the treatment of opiate addiction.

#### **Drug Treatment Service Provision**

Current approaches to treatment for opiate addiction include: substitute prescribing; supportive and psycho-social counselling; structured day programmes; inpatient or community detoxification; residential rehabilitation and after-care. Additional harm reduction takes the form of health education, needle-syringe exchange and testing for, and vaccination against, blood-borne viral infection (NTA, 2002). Some research has shown that drug users can recover without structured treatment (Biernacki, 1986; Stall & Biernacki, 1986), but others argue that this is rare (Hser *et al*, 1993).

The hierarchy of drug treatment goals (ACMD, 1988, 1989; Task Force to Review Services for Drug Misusers, 1996) endorses the principles of harm reduction, with the aim of minimising levels of social, medical, legal and financial consequences of using illegal drugs until the individual is able to abstain (DH, 1999). It has been asserted that in the UK this has helped to prevent a more severe HIV epidemic (ACMD, 1998), although recent reports recommend renewed vigilance, based on increasing rates of HCV (ACMD, 2000; DH, 2002).

### **Prescribed substitute medication**

All of the main treatment modalities have been shown to have had an impact on performance measures such as: numbers entering or being retained in treatment and becoming drug free; reductions in criminal activity; as well as in drug-related deaths (Gossop, 2005). Evidence of the effectiveness of substitute prescribing is already well-established, and it has been asserted that well-managed methadone maintenance programmes can achieve the aims of harm reduction, stabilising drug users until they are ready to consider abstinence (Donoghoe *et al*, 1998; Gossop, 2005; Ward, 1998; Witton & Ashton, 2004). It has been posited that this is particularly true when adequate dosage is provided under flexible, individualised regimes and needs-led treatment services (Gossop, 2005). Clinical guidelines recommend the use of methadone as a substitute prescription because it is longer-acting, simple to titrate and has been shown to be effective (DH, 1999b).

On the other hand, opponents of the use of Methadone Substitution Therapy (MST) have challenged this evidence base, arguing that it simply replaces one addictive drug with another and have pointed out its implication in many drug-related deaths, because of 'leakages' from prescribed medication to the street market (Newcombe, 1996; Stimson and Metrebian, 2003). However, overdose fatalities, often because of respiratory depression, appear to be more frequently associated with poly-drug use, commonly a combination of opiates, alcohol and benzodiazepines (Gossop *et al*, 2002b). Neale (1998b) found that addicts in her study had mixed views of methadone's efficacy, and while it had helped to reduce criminal activity and improved some measures of general health, there were a number of adverse side-effects. These included: profuse sweating; sleeping problems; constipation; and clients' dissatisfaction with appropriate dosage. Moreover, McIntosh and McKeganey (2002) have postulated that

methadone's impact on the length of treatment or addiction 'careers' has yet to be established. Some researchers have commented that even after twenty years of maintenance treatment, abstinence from heroin cannot be demonstrated and that opportunities for change may have been overlooked (Hiser *et al*, 2001).

Nevertheless, it is clear that external factors play an important role in treatment outcomes and social factors such as troubled relationships, unemployment and unsatisfactory accommodation may be deeply relevant (Gossop, 2005).

### **Treatment for opiate addiction in North Cumbria**

In North Cumbria, drug treatment services are delivered by both the statutory and voluntary sector, sometimes accessed by self-referral, but more often by individuals first contacting their own doctor. Those who desire or require a substitute prescription will need to consult a GP, and Shared Care (DH, 1999) with an NHS drugs worker, is almost universally practised in West Cumbria, and to a lesser extent in areas served by Carlisle and District or Eden Valley Primary Care Trusts (PCT). Additional supportive counselling and structured day-care services are provided by voluntary sector agencies. In North Cumbria, it appears that the prescription of substitute opiates is equally divided between methadone and Subutex (buprenorphine) (NCABS, personal communication, 2005) and mechanisms to minimise risk, such as the supervised consumption of methadone in community pharmacies, are already in place.

### **Criminal justice service interventions**

As part of a national policy, drug treatment may also be initiated by the criminal justice system when this is offered through schemes such as Arrest Referral, Drug Testing and Treatment Orders (DTTO) or Persistent and Priority Offender (PPO) programmes, under direction from the Courts. Turnbull (1999) has argued that interventions in the criminal justice system are most likely to be successful in engaging young white male drug users. However, it has also been reported that the gender ratio of drug users requesting treatment is now similar to those who approach community services (DH, 2002). Sondhi and colleagues (2002) have demonstrated that a higher proportion of women drug users engage in treatment by this route, and suggest that such interventions can present an opportunity for many women who may have previously faced barriers.

### **Interviewees' access to drug treatment**

Interviewees had accessed treatment in a range of different ways, including all of the fore-mentioned. Many women (18: 30), particularly those who were mothers of small children, said that they found the Shared Care Scheme convenient, since it allowed them to attend their local GP surgery for treatment. On occasion, concerns about anonymity could emerge when, for example, interviewees were recognised by practice staff, and Jan was anxious about disclosing her drug use to a family doctor whom she had known since childhood.

*Jan, 30 years*

*"I was embarrassed to tell him I was injecting. He was a bit disappointed because he knows I'm from a good family and I'm not really that sort. I was usually bubbly and happy-go-lucky but the heroin made us spaced out."*

It has been established that issues around travel and appointment times can create barriers for women seeking treatment for drug dependence (Gilbert, 1997; Marsh *et al*, 2000; Powis, 1996). Marsh and colleagues (2000) tried to improve access as well as treatment outcomes for women drug users and their children by providing enhanced family, medical and social services as well as transport, and found that this substantially improved outcomes. As a result of the topography of North Cumbria, communities are often dispersed and public or community transport can be limited or absent. In several cases (15: 30), interviewees lived some distance from the main towns and Michelle indicated the difficulties this could present for drug-using women. In this next extract, Michelle explained how awkward it was to collect daily supplies of methadone or attend her General Practice, because of limited public transport from the village where she lived.

*Michelle, 25 years*

*"It's hard. There are only two buses and in the holidays that means walking the kids down into town and it's nearly five miles so they twine (complain) a bit. Chloe's getting too heavy to carry too. Sometimes we can get a lift off someone and Liam and I usually take it in turns to go so that someone's there for the kids."*

Michelle added that help with childcare, such as a crèche, could assist mothers to attend appointments and this was echoed by other interviewees (6: 18). A mother of a twelve-year-old pointed out that the needs of this age group were often overlooked, and that the provision of supervised activities could help both of them. Bauld and colleagues (2004) suggest that diversionary activities

combined with 'issues-based' projects can assist young people of this age group, with substance misusing parents, to discuss concerns in a 'safe environment'.

Transport difficulties and rural isolation were also recognised by families intent on helping a daughter to resolve drug dependence, and in a couple of cases, parents had bought their daughter a car to facilitate attending drug services.

*Elaine, 24 years*

*"So Dad bought us a car, on the condition that I came home, and in the end I got chucked out anyway, because I was using. And that's where I am now, out in the wilds. It's all right, but it means I have to come in every day to pick up my medication, and that's a 40-mile round trip. Going home was good. The previous times, when I went home with a bad addiction, out in the middle of nowhere, no vehicle and you're just totally trapped there."*

Fiona also faced a similar journey to attend the community drug team, but she found this inconvenience more irritating because of apparent inequity, compared with her addict boyfriend, in her access to treatment. She also explained that her recent arrest and drug Treatment and Testing Order (DTTO) meant that her expenses were paid by the Probation Service, and commented that this advantage could seem to be a perverse incentive.

*Fiona, 24 years*

*"Went to the doctor in our village, but he said they didn't deal with drug users and people like that, so they refused. A country practice, so they referred us to the clinic in the town centre, and I had to go there. But then I found out after that, my boy-friend got treatment off them. I was angry, really, because they refused me, but I think they judge you worse as a lass who's a druggie. They prescribed him Valium and Subutex too. I had to come twenty miles to get my prescription, my methadone, but now I'm on a DTTO they pay my petrol. My dad give us a car to help me. But it wasn't fair to help my boyfriend and not to help me."*

### **Interviewees' waiting time for treatment**

A related issue raised by most of the interviewees (23: 30) was length of the waiting time to see a drugs worker for assessment before beginning a course of treatment. Interviewees reported waiting from four weeks to four months for an appointment, and it has been asserted that long waiting times can discourage potential service users (Donmall *et al*, 2005). Strang and colleagues (2004) have claimed that shorter waiting periods result in more people beginning treatment successfully and that this, in turn, results in better outcomes. Having made the decision to give up addiction, and having negotiated the real and perceived

barriers to approach agencies, it seemed that interviewees' urgency to enter a treatment regime became intense.

An Audit Commission report, *Changing Habits* (2002), reviewed the commissioning and management of drug treatment services and identified problems with waiting times and care management, and pointed out that some groups, including women, were under-served. One notable outcome was the publication of *Models of Care for Adult Substance Misuse Treatment* (NTA, 2002) to provide a framework to try to resolve many of the evident difficulties. This national drive to improve the quality of drug treatment services has also been influenced by wider developments for improving health and social services in general and they are consistent with the NHS Plan (DH, 2000), and a stated desire for a patient-focussed and patient-led health service (DH, 2005a). *Models of Care for the treatment of adult drug misusers* (2002) like other national service frameworks aimed to promote quality provision, informed by a research evidence base and guided by consistent performance monitoring. Furthermore, recent NHS quality standards affirm the importance of striving for equity in care eg *Standards for Better Health Core Standard 18* requires that 'Healthcare organizations enable all members of the population to access services equally and offer choice in access to services and treatment equitably, with implications for race, gender, sexual orientation, individuals with children or work commitments and those living in rural communities' (DH, 2004b).

Despite a significant recent expansion in local drug service provision, there are still difficulties with reconciling capacity and demand, and waiting times for assessment by drug treatment services can vary throughout North Cumbria (Cumbria DAT, personal communication 2005). Current research indicates that a rapid intake to treatment, coupled with motivational interventions and intensive ongoing support, can impact on engagement and retention in treatment (Ashton & Witton, 2004; Donmall *et al*, 2005; Stark, 1992). Many women (19:30) asked for a particular note to be made of their concern about waiting times, and described a range of experiences to illustrate their viewpoints, and the desperation and frustration they conveyed is portrayed in the following extracts.

Sharon, 22 years

*"Horrible, it was to go for the first time. I felt like dirt, just scum. But going to the doctor wasn't the end of it. It was waiting to see Drug & Alcohol. I kept going down to the surgery because it wasn't getting better. I was getting a bigger and bigger habit. I was desperate, losing more weight, and all they said was, there's a waiting list, and my mam ended up phoning, and she kicked up a bit of a fuss, and I got an appointment two days later. It really got to me. Fifteen weeks is hard, just impossible. My mam thought I was lying about the appointment and that didn't help things either."*

Jo, 30 years

*"Well, when you go to the doctor, it can then be three months to get your appointment for the drug counsellor, whereas it's maybe took you a long, long time to pluck up the courage to go to the doctor in the first place. And then three months seems an impossible time away. I mean, I know that there are waiting lists, but you have to wait and wait and wait, and by that time you can be more tempted or just give up. By that stage you've maybe got together a bit more money and you could slip back on to it. When you're stuck money-wise, and you've exhausted everything, that's often when you decide the only option is to go for help. You know that if you don't go on the prescription you'll be really poorly."*

Cindy, 17 years

*"I went back to the doctor and he said 'You've had a lot of chances, you're just going to have to wait. I'm not prescribing for you without her assessment.' 'Fair enough' I thought but then it ended up waiting three months. And I had to find a way round it and I ended up buying me Subutex off the streets and grinding it up to inject, might as well have got heroin. I felt desperate – there seemed to be no way out. I know girls who are on waiting lists and they're terrified they'll lose their children just for being on it. If you've decided it's time to go you can't cope with waiting for months."*

However, mechanisms should be in place to enable 'fast track' access for those drug users who are deemed particularly vulnerable and for whom an early intervention is critical. This includes very young or pregnant users, as well as those who have been arrested for drug-related crimes, and offenders are then offered rapid access to treatment and monitoring through the criminal justice system. Those women who were currently attached to such schemes as Drug Treatment and Testing Orders (DTTO) praised the availability of a variety of diversionary and training activities, which are integral to help recovering addicts to restructure their lives (Gossop *et al*, 2002a), and Kath's comments in the following extract were typical.

Kath, 28 years

*"It's been really good. They (DTTO drug workers) can help you find a job and sort out a flat, but for me the big thing is filling up my time with appointments and courses, at least the daytime. In the evenings I stay in and watch TV and play with the kids so that keeps me out of trouble. You need some alternatives to*

*using. I find it hard but I'd like to complete and I think it gives you something to aim for."*

It has been established that addiction rehabilitation is fundamentally dependent upon reintegration into housing, employment and education or training, supported by aftercare services to promote a sustainable recovery (Gossop *et al.*, 2002a; McIntosh & McKeganey, 2001).

### **Choice of treatment**

Many women were well-informed about some of the fore-mentioned debates around the use of methadone and were keen to engage in the decision about their choice of medication. Several interviewees (10: 30) mentioned concerns about its addictive nature and quoted cases of those who had *"been on it for years"* along with wry comments of *"they don't call it methadone maintenance for nothing."* Sara was one who would have preferred some alternative to this substitute medication, since her confidence in this treatment was tainted by past experience of trying to reduce her dosage. In this next extract she described this interaction with her drugs worker, and indicated her dissatisfaction.

*Sara, 26 years*

*"I didn't want to come back on methadone. I told her (drugs worker), 'You can pay me a million, but I don't want methadone, it's so hard to come off.' I mean heroin, you don't feel that much. Four days and you can be back to normal, more or less. But you need something to replace it in your life, a job or something, because the dealers will just come to your door, and you'll see them at the Social or whatever. methadone was the only thing she'd put me on, didn't even mention Subutex, and I told her how much it hurt to come off before. I'm not looking forward to it."*

Some interviewees mentioned lay beliefs about the effects of methadone and these ranged from it *"getting into your bones"* to mistaken powers of contraception, as Lara explained in the following extract.

*Lara, 28 years*

*"Well, I've heard the doctor say, you can't get caught (pregnant) on methadone - you don't have periods and it affects men's sperm, too. When I went to the doctor I was five and a half months, but they wouldn't let us cut down the methadone at all. But I wanted to try so that there was less for her to come off."*

Several women (15: 30) had experience of both types of substitute medication, and advocates for either methadone or Subutex were approximately equal in number, and the following extract was typical. Linda had eventually realised

that she derived therapeutic benefit from methadone, as well as becoming aware of its impact on harm reduction, and she explained how this affected her.

*Linda, 23 years*

*"I didn't really enjoy the heroin then, but it was the thought: 'Oh I can't cope without this, can't drop it'. So I was never really stable, like, at first. But once I'd got a little bit stabilised on the methadone and knew how much it helped us, I just realised, if it wasn't for them giving me it, I'd have just got Subutex off the streets, eh. I'd have just crushed them up and injected them, done it myself because I'd done that before."*

On the other hand, Subutex, discourages the further use of heroin since doing so can induce withdrawal symptoms: advocates said they "*felt better on it*" and were glad of the removal of this temptation which had previously prompted relapse.

Most of the women (20: 30) presented this issue of choice as significant for addicts' engagement and retention in treatment. Interviewees proposed that "*being listened to*" in a welcome participative approach, as clinically appropriate, was desirable and more likely to achieve shared goals in drug treatment.

### **Interviewees' relationships with therapeutic professionals**

Many of the women expressed gratitude for the care they had received from local drug treatment agencies. Relationships with staff were often said to be good and there did not appear to be any overt conflict between them, although the issue of prescribed methadone dosage often remained contentious. Recent guidance recommends that dosage adequate for individual need in methadone maintenance can lead to improved outcomes, and that lower levels may undermine the provision of optimal services, as well as jeopardising the relationship with professionals (Ashton & Witton, 2004; Gossop, 2005; Lilly *et al*, 1999). Researchers have emphasised the importance of mutual agreement in deciding appropriate dosage levels (Jones *et al*, 1994), and Gossop (2005) argues that flexibility and responsiveness is required, implying holistic care and services matched to needs, in the pursuit of agreed and shared goals.

Some American studies have asserted that empathetic staff can have significant impact both on retention in treatment, and on discouraging continued illegal drug use (Florentine *et al*, 1999a, 1999b). It appeared that for women in

particular, the most important factor was feeling that their key worker 'cared about them', but for men it was 'the level of helpfulness' that was rated highest (Florentine *et al*, 1999a, 1999b). It seemed that an individual's perception of rapport and empathy greatly depends on the professional's ability to facilitate communication, but it must be acknowledged that with some service users this may be challenging (Bell *et al*, 1997; Simpson *et al*, 1995). However, some observers have pointed out that women drug users may experience judgemental attitudes from some health professionals (Deehan *et al*, 1997; Faugier & Sergeant, 1997; Philip *et al*, 1997), who may regard them as 'anti-social, unhygienic and irresponsible' (Lawless *et al*, 1996: 1371). In this extract, Michelle explained the effect on her treatment progress of an unsatisfactory interaction with the doctor responsible for her care.

*Michelle, 25 years*

*"I had a bad relapse before Christmas. Doctor reduced them methadone too fast and it was bad. The withdrawals were really bad, both of us. I was shaking and writhing on the floor. It was that bad my mam even gave us money for heroin because she couldn't bear to see us in such a state. He just wouldn't listen - we weren't ready for it. But I came back again with a different doctor and I'm getting on much better now."*

Lara described her own setbacks from a similar experience with staff, as well as her strategy to refute allegations that she had been using other illegal drugs. This next extract illustrates Lara's version of this confrontation, and the impact of a breakdown of trust between them.

*Lara, 28 years*

*"He (doctor) could be very nasty, shouting at us and the Social Worker too, 'cos I kept testing for benzos, and I found out later from the other doctor that the test had been faulty. I ended up keeping receipts to say I was clean and gave copies to my solicitor. I needed to have the proof that I was trying. You don't need a doctor to be shouting at you. I was doing my best."*

Nearly half the mothers (8: 18) made it clear that even once engaged in treatment, issues of trust around the welfare of any children were fragile. Gemma explained that she had pointed out a small lump behind her baby's ear and that her drugs worker had immediately contacted Social Services with concerns about child abuse. After a hospital review appointment, accompanied by two Social Workers, the lump was pronounced a benign haemangioma.

Gemma said she felt betrayed and demotivated by this experience and portrayed her feelings in this extract.

*Gemma 27 years*

*"But because she's (drug worker) contacted Social Services I've now got them on my back – I now have to defend myself to them. The Social Worker said the hospital report said it was a birthmark. 'Your kids are beautiful and well looked after', she said, 'I don't need to see you again'. You can't trust them. And it's not just me she's done it to – I've heard it from lots of others – phoned Social Services behind their backs. People with kids are very wary of Drug & Alcohol – frightened to tell them anything in case they get their kids took off them basically. Before all this I felt I could talk to her."*

Becker and Duffy (2002) considered this anxiety about child welfare allegations to be an important barrier to engaging mothers with drug treatment services. In order to maintain therapeutic relationships, they suggested ensuring that all women are familiar with the child protection policy of the agency. As an example of good practice, they mentioned one service which involves the mother from the beginning, by suggesting that she herself makes the initial contact to the Social Services department.

### **Interviewees' views on gender-specific treatment provision**

The national treatment framework, *Models of Care for the treatment of adult drug misusers* (NTA, 2002) has discussed the need for gender-specific treatment provision, and has recommended a relevant ratio of women staff members for the service user population. However this document has also recognised that women drug users are not a homogeneous group, and that some women will prefer to be treated by a male counsellor. *Models of Care for the treatment of adult drug misusers* (NTA, 2002) has noted that group therapy can be particularly beneficial for drug-using women, especially as single-sex provision. It has recommended group work as part of the case management of drug users of both genders after assessment, but highlights women drug users as 'a special group' for consideration.

Previous research has advocated the creation of women-only groups since some women may be intimidated by men (Hodgins *et al*, 1997; Powis, 1995), particularly if sexual abuse by men has featured in their case histories (Becker & Duffy, 2002; Broom, 1994), and they may even feel threatened by male staff (Copeland, 1992a). Indeed, some commentators claim superior treatment

outcomes in segregated settings (Copeland & Hall, 1992b; Copeland *et al*, 1993; Dahlgren & Willander, 1989). Gilbert (1997) asserts that female counsellors may be more appropriate for women drug users, but others contend that there is little supporting evidence, and that the nature of the service and its delivery are more important (DAWN, 1994; Thom & Green, 1996). Gossop (2005) has reported that service users are more likely to engage in treatment when they feel that their needs are listened to empathetically, along with helpful positive responses. He goes on to argue that a good therapeutic alliance mediates other variables such as age, gender, criminal or substance misuse history, or even initial client motivation (Gossop, 2005). This has been corroborated by an American study which has refuted the need for allocating drug addicts to counsellors according to race or gender, claiming that neither retention nor outcome is adversely affected (Sterling *et al*, 2001). Other researchers have asserted that it is the characteristics of the counsellors themselves which have the more positive effect upon outcomes (Florentine *et al*, 1999b).

In North Cumbria, none of the interviewees expressed a preference for the gender of counsellors or for general women-only sessions, but none of the women was attending group sessions. Many women (20: 30) attended their doctor's surgery for individual counselling with drugs workers, who might be male or female, but other interviewees (14: 30) also came to community drug team services instead, or in addition. Kath mentioned that in this latter situation women-only sessions for some routine tests could be beneficial and she explained her reasons. In the following extract, she indicated that in a mixed group of clients in a waiting room she had sometimes felt oppressed by people whom she had known as dealers.

*Kath, 26 years*

*"Another thing, at Drug and Alcohol everyone has to come for their urine test at the same time with the DITO and everything, and sometimes you meet people you'd rather not see, because you know they're still dealing and that, and you can get a bit of pressure then, and that can be hard. It might be better if that was just a women only session, but I don't know."*

### **Sexual health promotion and harm reduction**

Despite reports of many good therapeutic relationships, it seemed that some issues were difficult to broach with interviewees. Even though sexual health remains an important element of harm reduction with drug users, and many

women (28: 30) were or had been in relationships with male addicts, none said that it had ever been discussed. Contraception was another topic which was apparently off bounds, although many women (12: 20) acknowledged that their pregnancies were unplanned, and, in a few cases (4: 20), unrecognised for nearly six months. Beliefs about reduced fertility linked with opiate use prevail, and women using drugs chaotically may not prioritise either oral or barrier contraceptives. Recent guidance advises that all women should be given the option of long-acting reversible contraception to reduce the number of unplanned conceptions (NICE, 2005b), which could offer a non-stigmatising intervention for women drug users. Miller (1996) found that 60% of women drug users in her study were not using any form of contraception and that 50% had reported unwanted pregnancies which had led to terminations. Furthermore, Miller (1996) argued that the Shared Care model of treatment provides an opportunity for good practice in sexual health and contraception advice, since only 30% of her participants perceived that Family Planning services were appropriate or had ever used them.

### **Interviewees' views about counselling treatment services**

It has been recognised that the benefits of methadone maintenance are enhanced and complemented by supportive and psycho-social counselling (Ashton & Witton, 2004). Psychological therapies such as cognitive behavioural therapy (CBT) can often have a significant effect on substance misuse. It seems that women in particular benefit from therapy which targets sensitivity to interceptive cues linked with drug craving, more than supportive counselling alone (Pollack *et al*, 2002).

Some interviewees (7: 30) had noticed the benefits of similar approaches and described how it had helped them to manage and prevent relapse, and they also reiterated the need to extricate themselves from former addict networks when trying to succeed with drug treatment. A few women (5: 30) remarked that some counselling needs were particularly relevant for women and the next section will account for the women's opinions. This does not mean that male drug users do not have equal need for effective counselling support, but variation was noted by interviewees and a short review of the evidence base has indicated that this difference may be relevant.

### **Interviewees' specific issues about counselling services**

Cindy was one interviewee who pointed out that she had observed gender differences in the reasons for involvement in problem drug use, and indicated that several women addicts known to her had suffered some form of abuse. She said she believed that many women needed more psychological counselling support as part of drug treatment, because of these predisposing factors.

This perception of the aetiology of women's drug use is supported by an evidence base which indicates differences (Becker & Duffy, 2002; Bennett & Lawson, 1994; Blume, 1990; Copeland & Hall, 1992; El Bassel *et al*, 2000; Gilbert *et al*, 2001; Hien & Scheier, 1996; Horgan *et al*, 1998; Najavits *et al*, 1997; Reed 1985; Robbins, 1989; Root, 1989; Ross *et al*, 1988; Kosten *et al*, 1985; Swift *et al*, 1996; Underhill, 1986; Weaver *et al*, 2004). Furthermore, Marsh and colleagues (2000) have argued that many women drug users also experience more chronic physical and mental health problems, in addition to lower levels of education, employment and income than male counterparts. It has already been recommended that women drug users entering treatment should be routinely assessed for co-morbid mental health issues (Blume, 1990; Boyd, 1993).

Furthermore, it has been established that women drug users in the National Treatment Outcomes Research Study (NTORS) demonstrated greater psychiatric morbidity with higher rates of depression and suicide (Marsden *et al*, 2000). This has been corroborated by a similar Scottish study which has examined drug treatment outcomes for a large sample of PDU sixteen months after contacting treatment services. It has been reported that women were twice as likely to experience depression, and about three times more likely to report episodes of self-harm or parasuicide (McKeganey & Bloor, 2004). Green and colleagues (2002) have asserted that attending to these gender-specific characteristics of increased levels of co-morbidity has the potential to improve outcomes, since longer retention in treatment tends to predict better results (Luchansky *et al*, 2000). However, this does not mean that young men do not need appropriate gender-specific counselling provision for similar distressing issues which may also have underpinned their drug dependence.

In this next extract, Cindy shared her experiences and opinions and also suggested that a drop-in centre could provide support to prevent relapse and could be valuable for those who were vulnerable.

*Cindy, 17 years*

*"I think it would stop you relapsing if you could drop in somewhere for a bit of support. From what I know it's different for girls that get into heroin. I don't know any who are on it that don't have problems and I think you need help to sort a lot of that out. A bad background, bad things in their lives. With the lads it's different, they're usually just in it for a laugh."*

Another interviewee who mentioned specific counselling needs was Fiona, who was convinced that depression, which she claimed to have suffered since early adolescence, was the predisposing cause of her substance misuse, but that until recently she had faced barriers to diagnosis and treatment. Recent guidance recommends that young people experiencing anxiety and depression, should be supported by a range of non-medical integrated responses by both specialist and mainstream organisations to prevent any problems becoming enduring (NICE, 2005a).

*Fiona, 24 years*

*"I went to my doctor about it a while ago, but he said he couldn't prescribe for me until I'd sorted my drug problem out. But really I had the depression before I was into heroin. I go into these bad depressions and I go back to it because it seems to help. My new worker has got me sorted out with anti-depressants at last, and I'm going to see a CPN soon. Last week we were talking about a proper therapist, too, like a private counsellor. My dad says he'll pay for it, however much it takes. It's a really expensive thing, but I'd like to give it a try."*

### **Informal support to complement drug treatment services**

Most of the interviewees (22: 30) identified an unmet need for informal support outside appointment times in North Cumbria, and they strongly recommended that a recovered female addict would offer the most credible guidance. They explained that another woman who had recovered from addiction would "really understand" the difficulties they might be experiencing. It is possible that this kind of support might be beneficial to male drug users and this question remains, but this study retained a focus on the influences upon this sample of women drug users. Interviewees indicated that this type of intervention might also help to combat the depression, isolation and low self-esteem which persists among women drug users in treatment (Mondanaro, 1989; Murphy &

Rosenbaum, 1990, 1988; Reed, 1987). The women frequently declared that "a lot of people would rather talk to someone who's been there" and they conveyed that another woman addict would understand that situation best. Furthermore, the majority of interviewees (20: 30) hoped that once they themselves were drug-free they could assist another woman drug user's recovery, since their own experience would be authentic. The following extract illustrated some of the important features which women depicted in this type of intervention: a shared culture; genuine understanding of the daily issues for women drug addicts in treatment; time to listen; and non-judgemental support.

*Linda, 23 years*

*"Well, someone to talk to that knew what you were talking about, first-hand knowledge, not just out of books. Not book-learners. Maybe someone that's been there, come clean and wouldn't judge you or get your kids taken away. You can get so isolated going through it all. It's important that people make the time to listen. It would help just to chat about your worries and that, just to get you over a bad time. I mean, I'm really pleased if I'm helping you with all this, because I would like to think I could help other people get out of the gutter."*

Furthermore, the overwhelming majority of women (23: 30) articulated the need for some kind of drop-in service in North Cumbria, and linked this with strategies to prevent relapse, which will be discussed later in this chapter. Necessary features of a drop-in centre included: accessibility; anonymity; and non-judgemental attitudes, as well as the provision of a range of services in one location. In this next extract, Jan shared her vision of such a local facility.

*Jan, 30 years*

*"Somewhere to go where nobody knows why you're there – even for the methadone. It can be quite degrading – even if they have a back room it's the only reason anyone goes there. Somewhere central but anonymous where you can just drop in if you're not sure about something. A little clinic where you can get help right away or nearly, and maybe needles too. Where you could be going in for anything and safe and people would take you as you are."*

Becky was one interviewee who corroborated the other women's views of this unmet need, but expressed some reservations that this initiative might be abused by dealers keen to sustain and develop their market, "because you'd get all the smackheads in one place."

### **Pharmacies and pharmacists as treatment providers**

Most of the interviewees (23: 30) asserted that the greatest disincentive to entering treatment and persevering with methadone was the need to take it under the auspices of the Supervised Consumption Scheme. This operates in community pharmacies, and the main purpose of supervision is to reduce the 'leakage' of prescribed methadone on to the street market, because of links with some drugs overdose deaths. The majority of women (20: 30) said they felt humiliated by being identified as drug users, and they presented many instances of awkward encounters and public censure.

*Sara, 26 years*

*"It was more embarrassing going there than in the city where I was a student, because it was a chemist, not a place for junkies, a normal chemist. I used to have a drink before I could go in. You don't like everyone knowing you're using, and they weren't very particular. And methadone, they make you drink it in front of everyone, it's humiliating. But now I've found a different chemist and they're brilliant. They wait till it's quiet, or let you go behind the counter. I mean, some places I've been, they stand there with little cups and yell 'Sara, it's your methadone'. I was so angry. It's hard enough as it is without the whole town knowing."*

Anonymity has been said to be 'a rare social option' in non-urban communities (Henderson, 1998), and scrutiny was claimed to be keenly felt by those requiring methadone prescriptions. It was repeatedly emphasised by interviewees (27: 30) that public consumption of medication was a significant deterrent for women, who may jeopardise more by disclosing their drug dependence (Ettorre, 1992; Rosenbaum, 1981a). However, this self-consciousness could equally be experienced by men and people of either gender attending drug services in other locations. However, Henderson (1998) has argued that the 'higher visibility' of any public behaviour in non-urban settings can increase the likelihood of more extensive blaming by other sections of the community. She has gone on to point out that fear of this 'labelling' as an addict discourages presentation to services, and has the potential to make drug use more difficult to treat in this type of setting. Nina recollected her feelings when she first began to use methadone and in the following extract, described the issues involved.

*Nina, 27 years*

*"But that was a lot worse because you have to be in the place for longer than for pins. At first I didn't think I was going to stick with it, because everyone is watching, and you've got to drink it in front of everyone. You wouldn't have to do that for anything else. People you know are there, and they tell your parents. It's*

*all the same in a place like this. Everyone knows your business, and the bits they don't know, they invent."*

Lara mentioned similar embarrassment about using methadone during her admission to the local Maternity ward, and it has often been highlighted that women using maternity services have particular concerns about confidentiality (Clarke, 1999; Hepburn, 1993; Macrory, 1997; Stewart, 2000). In this extract Lara provided an account of her embarrassment in taking methadone treatment as a newly-delivered mother, and also described the catalytic effect of witnessing her baby's withdrawal symptoms.

*Lara, 28 years*

*"Another thing was having to take the methadone in the hospital pharmacy corridor, and I thought, 'This is all I need, everyone here knowing I'm an addict'. They'd phone down to the ward to say it was ready and I'd have to take it in front of everybody. I was on 50 ml when I went into hospital, and I got myself down to 30 in hospital, and then 20 when I came out. But I tell you one thing: seeing my little lass going through that rattle, that really opened my eyes to it all. I felt like a coward, a real waste of space."*

However, she offered praise for the pharmacist who supported her through her drug treatment, and this particular group of professionals was singled out by many interviewees. Lara described her attitudes and beliefs in detail, and explained the anxieties she said were felt by other drug users on methadone treatment, which were often intensified by myths and addict folklore. She recommended some helpful interventions, and outlined the type of intervention which had encouraged and supported her to become drug-free, and this is portrayed in the following extract.

*Lara, 28 years*

*"Yes, it was a month after I came out of hospital with Alice. Then you know that sickness everybody had a while back, vomiting and all that. Well, I was throwing up all the time and I just didn't go back on it again. I was on 20 ml, but not a drop more after that. I wanted to be off all of the stuff. The chemist says to us, 'By the time the sickness stops in a few days it'll be out of your system. Hang in there'. When I wanted to come off the methadone, the big thing that kept us back was the fear, the fear of not knowing how bad it would get, would it get worse before it's better. These are the things they need to explain to you. When you're on methadone, people tell you it seeps into your bones, all sorts of rubbish. I only had a few twinges in my legs, and terrible sweats. I mean, he told us about Dicor; it's a roll-on that stops your sweats. It made such a difference because I felt so dirty and sticky. They need to share the knowledge to help people more - think how people will live. Mind, they gave me some really good support in the Chemist."*

*He used to give me little samples of perfumes and make-up, and stuff for the kids as a kind of reward to encourage me. It really made a difference."*

It seemed that many community pharmacists throughout North Cumbria had developed productive therapeutic relationships with drug user clients. This had not passed unnoticed by interviewees, and the following example illustrates the impact of a positive interaction with a local pharmacist. Elaine went on to explain that feeling valued as an individual had enhanced her self-esteem, and had instilled confidence that she did have the personal resources to persevere with her treatment for addiction.

*Elaine, 24 years*

*"Not everybody likes doing that, but at the one (pharmacy) I go to, they're all dead nice. They'll take you round the back sometimes, and then you don't have to drink it in front of everybody. The pharmacist is great with me: when I told her I was pregnant, she was very kind. They have those special posh ginger biscuits for their coffee time in the shop. And before my morning sickness finished, I just couldn't drink it all at once. Sometimes I'd bring it straight back, and she'd sit me down - 'just take your time' - and get me a glass of water and a couple of ginger biscuits to help me feel better. It was a real encouragement, that someone would take that much trouble. Dead supportive, the kindest pharmacist I've ever met."*

## **Relapse**

It has been remarked that illegal drug use is a 'chronic relapsing condition' (O'Brien & McLellan, 1996; Task Group to Review Services for Drug Misusers, 1996), and most of the interviewees (28: 30) bore testimony to this assertion. It has been estimated that relapse may affect up to 90% of those who attempt to quit their addiction (Christo, 1998) and this cycle of intervention, abstinence and relapse has in itself been termed a 'treatment career' (Hser et al, 1997). Gossop (2005) has recently reviewed treatment outcomes in England and Wales and has declared that the trend is variable but generally positive, with many users fluctuating between improvement and deterioration, some achieving reductions in problem use and some remaining drug-free. McKeganey and Bloor (2004), reporting on a similar study in Scotland, have pointed out that although a reduction in illicit drug use, injecting or sharing equipment, can be demonstrated eight months after beginning a treatment episode, after a further eight months there was no evidence of incremental improvement. In this latter study it was reported that outcomes appeared to be less favourable for younger users (aged under 28 years) in terms of their criminal, illicit drug-using and

equipment sharing behaviours; and in indicators of poor mental health (McKeganey & Bloor, 2004).

Although they found it extremely frustrating and demoralising, many interviewees (18: 30) believed that they had learned more about their dependence from each episode of relapse. They had no hesitation in explaining the cues for relapse, and these were not mutually exclusive. Triggers included: boredom with a drug-free life; loneliness; the need for a shared "treat" with other drug users; an emotional trauma; or because their domestic arrangements, usually with a male drug user, brought them overwhelmingly close to a supply of heroin. Sterk (1999) has pointed out that external factors are usually attributed to relapse rather than the individual's own agency. It was clear in the women's accounts that social isolation seemed inevitable until new friendship networks were established, but interviewees said that the personal costs attached to implementing this change were great. Aware of the influence of contact with other drug users, the women often employed extreme strategies to avoid meeting former associates, as Pauline portrayed in the next extract.

*Pauline, 39 years*

*"I was sitting in the house all the time with the curtains closed, hiding from people all the time. Some of them just won't take the hint that you want to sort yourself out. Every few days they're coming to the door, 'I'll buy you a bag, I'll buy you a bag', I think they forget that I'm nearly 40. In another 20 years, I'll be 60, a pensioner and done nothing with my life."*

Lara's response to seeing former drug-using associates was more complex and she explained that she would not ignore them, but neither could she spend time with them. In a small town it can be very difficult to avoid people entirely and, for example, she still felt bound to assist an addict in an overdose crisis. Her expressed emotion was one of shame to see the squalid state that these former addict associates presented, reflecting that this had been her former self. She claimed that this had strengthened her resolve in her new identity as a non-drug-user, as well as her determination to remain drug-free. Lara was the only interviewee who claimed now to be abstinent of any illicit drugs.

*Lara, 28 years*

*"I'll talk to them but I can't pass someone in trouble, especially as an ex-addict myself. I'll talk to them but I can't be with them. I've been needle-mad, so I can't*

*associate. When they're in my face, I'm so ashamed, not of them, but of myself to think that was me. One day they'll come off, but that's got to be their choice."*

### **The influence of a male partner upon drug treatment**

Consistently, the influence of a male drug-using partner upon treatment was presented by interviewees as a cue for relapse, and most of the women (20: 28) mentioned that it was impossible to co-habit with a man who was using heroin at this time. It may also be surmised that a male addict trying to cease heroin use might find it equally difficult to live with a drug-using partner. A few (3: 30) women indicated that they believed that they themselves had exerted a negative influence on their partners' attempts to end heroin dependence. However, it is possible that this influence on behaviour may have more to do with the close association within intimate relationships (Jamieson, 1998), rather than being derived from gender dynamics. It has already been noted that a greater proportion of female drug users tend to be in relationships with male counterparts (Davies, *et al*, 1996; Gossop *et al*, 1994; McKeganey & Barnard, 1992), and that male drug users tend to choose non-addict partners (Donoghoe, 1992; Kane, 1991). In this study, the overwhelming majority of interviewees (28: 30) had been in relationships with male drug users, and they often (20: 28) said they linked the setback of relapse with the presence of a boyfriend: Jeannie's statement in this extract was typical of the women's remarks.

*Jeannie, 23 years*

*"I've had six partners, and every one have been users. I need to get clear of all that before I can get involved with another man: that's been my downfall, getting back in with someone who's using."*

Interviewees perceived that it was common for a male partner's influence to compromise the progress of treatment, and Rhodes and Quirk (1998) have confirmed that there can indeed be a perverse effect between couples. Linda explained that when both she and Ryan (partner), were attending treatment, they often sabotaged each other's chances of becoming drug free by ensuring that the temptation of heroin was available. However, after his recent release from prison as drug-free, she now claimed that her partner's example had been an encouragement that recovery was possible.

*Linda, 23 years*

*"He's made me so proud, and he's never touched the smack since he's been out of prison. He's given me a lot of back-up, showed me it could be done. I mean when we were both coming for treatment we almost set each other up, you know. It was too much of a temptation if you thought the other one had got a bag."*

All of the women (28: 30) who had ever been in a relationship with a male drug user asserted the potency of this influence, and many (22: 28) said they had to part from him in order to try to resolve their dependence. In some cases, when partners (6: 28) were serving custodial sentences, interviewees (5: 6) said they had ended their relationships rather than lose the benefit of drug treatment on his release. Those women (10: 28) who were still living with an addict often spoke in terms of his selfishness, although Elaine, who was expecting their baby, conceded that Alex (partner) had stopped injecting in front of her to help to reduce her drug cravings. Morrison and colleagues (1995) have noted the destabilising influence of an addict partner and recommend that a couple are offered joint treatment for their addiction to encourage mutual support.

Other interviewees (16: 28) remembered the strain of trying to avoid heroin when their partner was dealing from their home, and that this lure had been the trigger for relapse. One exception was Cindy who was still living with her partner, and she claimed that they were making good progress with drug treatment, because of their strategy to give up heroin in sequence. She intimated that in their case the relationship had not always focussed entirely on heroin, and other mutual interests were beginning to re-emerge to promote a drug-free shared life together. In this extract she portrayed the rationale for their plan to optimise treatment for addiction.

*Cindy, 17 years*

*"Me first and then him (partner). Well if we'd come off together we'd have been rattling together and we'd have been more tempted. It has been better like this and we've helped each other when we needed it. One had to be OK to keep the other on the treatment and he never, ever used anywhere near me. We've encouraged each other when we've needed to so that we've both got clean now. Wouldn't have worked otherwise."*

### **Relapse Prevention**

Some of the women had developed insight into strategies to help resist relapse and had often tried to find diversionary activities, although this could be very difficult on a restricted income. Interviewees expressed opinions on practical

service developments which could support the recovery process: ideas similar to the following two were expressed by most of the women (23: 30). These proposals focussed upon increasing access to supportive individuals whom they believed really understood the stresses and strains which were currently confronting addicts. In the first extract, Elaine promoted the idea of a centre where immediate support could stave off relapse, while Sally believed that a telephone help-line could be of value. All of the interviewees who commented upon similar ideas emphasised that it was essential that individuals who *"really understood"* were involved as helpers in these interventions.

*Elaine, 24 years*

*"What is there left when you haven't got the drugs? Not much, really. Maybe somewhere to drop in that was safe, that would be nice. Sort of like a coffee centre. Even some time if you thought you might be tempted to use, you could call in for a chat. Ten minutes could change your mind. When you have a craving for something, you know, the cravings come and go. Gradually they'll fade away if you can find something else to do, they sort of peak and then they'll pass. Something to help you through that could make a big difference - you'd be halfway there."*

*Sally, 40 years*

*"Just someone there to support and listen and confide in. Help me sort out the problem in my head. It's like a merry-go-round when you've got a problem, a carousel you can't get off, and drugs are the only release to stop you spinning away. Somewhere local that you could phone in if you're in a crisis, very often the best person to help is someone who's been there themselves. They've got phone lines for parents and that, but if you're a user, and something's happening for you that seems like a crisis, just to know you could speak to somebody could make all the difference to relapse or not."*

It was often explained that ceasing heroin left a void which could be difficult to fill, particularly when avoiding addict networks usually resulted in social isolation. The majority of interviewees were unemployed and had limited financial resources available to procure recreational outlets. Interviewees invariably said they believed that some form of informal support network and diversionary activity could mitigate their vulnerability to relapse.

### **Personal appearance and loss of confidence**

Most of the women (22: 30) confided feelings of distress that their personal appearance had been dramatically affected by the use of heroin and the related lifestyle (Malloch, 1999). They pointed out the impact of serious weight loss

unkempt hair, drawn faces with sunken eyes and unattractive skin conditions, as well as broken teeth and dental problems which they often linked with the use of methadone (Taylor, 1993). Ettorre (2004:331) has argued that drug use marks the body and helps to determine low status for women drug users: she has quoted Bunton and Burrows (1995) in *'the emaciated stereotype of the amphetamine or heroin user'*. Furthermore, Epele (2002a) has pointed out the scarring and abscesses that can underscore society's definition of *'used and spoiled'* women (Epele, 2001). Several (7: 26) interviewees commented on having to wear long sleeves to hide injection scars, or of actively ensuring that injection sites were chosen in less visible areas of the body. Epele (2002a) found that women tended to avoid contact with friends and relatives because of shame about their appearance. Families and friends expressed shock at these physical changes and as Pauline declared *"You didn't need everyone telling you, you knew it yourself, it really got me down."* Most of the women (22: 30) said they linked these adverse effects with enduring and debilitating loss of self-confidence. Lara said she believed that this concern was particularly troubling for women, and averred that women's self-concept is closely linked with personal appearance. She recommended that lifestyle advice and support to improve general health and well-being might reap benefits in terms of women's retention and engagement in treatment, as well as giving them hope for the future.

*Lara, 28 years*

*"And someone to really help sort your own health problems out. Your skin gets so bad and your hair and my teeth, look at the state of them. There's such a waiting list for the dentist if you can get hold of one, they've all gone private. It would help women particularly if they could things like that sorted out. They'd feel better about themselves – give them a bit of strength."*

Renewal of personal appearance for many interviewees appeared to be, in part, integral to restoring their damaged identities as *'spoiled and polluted'* (Ettorre, 1992) women, mothers, wives or partners. Sue was one interviewee who spoke of the incentive of her young son's compliments on her improved looks, which encouraged her long-standing efforts to achieve abstinence.

*Sue, 32 years*

*"Jamie's six now, and this is the first time he's ever seen me drug-free. I mean, if your kid turns round and says, 'You like nice today, mum, you're beautiful', that's a very big achievement in itself. To feel his love for you means such a lot. When you're on drugs, you think you look all right, but you're not. I look at people now and I just know they're on gear, because they look drawn and grey and wasted."*

Nevertheless, it cannot be assumed that personal appearance is of lesser importance to male drug users, who often suffer emaciation and spoiled looks as a result of their addiction, and this type of intervention might also enhance men's retention and engagement in drug treatment programmes.

### **Building hope for the future and renewing self-concept**

The overwhelming majority of women (23: 30) pointed out the value of improving self-esteem as part of their drug treatment, perhaps resulting in greater self-efficacy, and they acknowledged it as a key component of preventing relapse. Ellie declared *"You can do so much more when you feel better about yourself"* and this was a factor that she and others were keen to articulate.

As mentioned by one interviewee at the end of the previous chapter, recognition of a *'spoiled identity'* and the need to recover and develop a new self, was selected by a few women (5: 30) as key to making progress with their drug treatment. Interviewees who had come to the conclusion that restoring their own sense of self was important, had discovered that through the disappointments of relapse, but were keen to share that self-knowledge. Sally was one interviewee who urged women to look within, to appraise and value themselves, and then to build a base for personal development, as she summed up in the next extract.

*Sally, 40 years*

*"You need to find yourself again, build your self-esteem, find the person you know you really are."*

In addition, Jeannie asserted the need to believe in a future better than a current addict lifestyle, and to be convinced that this improvement was achievable. In the next extract, she clearly articulated this viewpoint.

*Jeannie, 23 years*

*"It's not enough to do it for your kids or whatever. You've got to have willpower to want to come off for yourself. You've got to want it enough for yourself to feel you've got a future."*

The particular facet of optimism was highlighted by most women (24: 30) and Lara was one who recalled that it played a vital part in her plan for abstinence. In her view, more emphasis needed to be placed on reassuring drug users that successful and sustainable resolution of their addiction was possible and

achievable. She asserted that it was her drug worker's encouragement in her own personal resources that had supplemented the motivation to regain some self-respect, and to fulfil hopes for a drug-free future.

*Lara, 28 years*

*"Someone to say it would be all right, someone with that little bit of drive in them to give some of it to me. But they didn't say it, what I needed. Nobody. Not until I got Sam (drugs worker), and he knew what was needed. Doctors and Social Workers, they don't understand enough what it's like, don't listen in the right sort of way. Someone needs to say to you, believe in yourself, believe in us, and you'll get there, and I've seen some successes. They don't seem to know much about how to help you feel better when you're coming off."*

For many interviewees the thought of returning to *"what I was"* and to their dependent starting point eventually became abhorrent, and was often said to be *"too much to lose"*, as well as a further motivation to persevere with treatment. In particular, interviewees (20: 30) frequently related their drug-using selves to a gaunt appearance and filthy clothes, as well as the other distressing issues around children and families, which had alerted them to the depths of their dependence. Lara used an image of her renewed self, along with her family, as a talisman to support her continued recovery and drug-free status, and shared the following example to help women in a similar situation, in this next extract.

*Lara, 28 years*

*"When I got my kids back I got a proper family photo of them done, and that's my reminder of what I've achieved. I used to hate my photo took when I was on heroin. I was six stone and just a wreck, and a photo of the kids then shows them all pale and withdrawn and dishevelled, their clothes not ironed or anything."*

Furthermore, for many of the interviewees (17: 30) it appeared that the process of telling their stories provided an important vantage point to benchmark progress in drug treatment, and which affirmed their achievements. In this extract, Elaine shared her reflections on her own improvement and stage in the recovery process from drug addiction, and of the value of validating any steps forward.

*Elaine, 24 years*

*"But now, just as we're talking about this, talking about where I've come from, I'm beginning to feel that I'm moving on, like I am making changes, like I might actually do it this time."*

## Summary

This chapter has described interviewees' experiences of treatment for drug dependence, and it was often said that these could be mediated by concerns about revealing their status as drug-using women. It was evident that mothers were even more hesitant to engage in treatment than childless women, and conflicting childcare responsibilities could emerge in relation to their treatment. Transport difficulties presented as a barrier to attendance for some interviewees, but where Shared Care was in place, women were able to access treatment in their GP surgeries and appreciated this convenience. Families often supported an addict daughter or sister by providing a means of transport or childcare, but for some women this family relationship had broken down, apparently irretrievably, and many women claimed to be socially isolated when in treatment.

Some mothers mentioned age-appropriate childcare provision to enable them to attend treatment services. However, for many agencies, finding suitable space or staff for such a facility could be difficult, in addition to the requirements of crèche registration. It has been argued that outreach work, in the form of home visits, can compensate for the absence of childcare and this has proved successful in similar locations, to improve engagement and retention (Becker & Duffy, 2002). However, such outreach work does require light case-loads and a degree of flexibility, since women addicts often live hectic and unpredictable lives. Lone worker safety may also be a consideration, since many interviewees lived in potentially violent home circumstances, and drug-using partners could resent this personal intrusion. Some of the mothers said that accommodation for their children remained a gap in this particular area of service provision, and this had apparently deterred a few interviewees from considering this treatment option.

Once the approach to services had been made, interviewees claimed that lengthy waiting lists became an additional barrier to accessing the help they needed, and this becomes an issue for service commissioning and re-design. Interviewees often mentioned a need for informal advice outside clinic sessions to provide support and guidance. Many women believed they had the authentic knowledge and credibility, with suitable training, to provide a complementary service as peer mentors. From the knowledge gained from episodes of relapse, they also believed that their own first-hand understanding could support and promote

successful long-term recovery for other women addicts in North Cumbria. Interviewees praised the dedication of local staff, but issues of contention were both the waiting times for assessment, and choices in their treatment. The prescribing of substitute medication will clearly depend on clinical judgement, but many women felt they had a right to be involved in any deliberations, and to be given some options when that was possible.

It seemed that interviewees had often presented a diverse range of problem issues for drug services to address. These often included difficulties relating to: general or mental health; social or financial issues; housing; education; training; employment; or legal problems. Treatment styles which interviewees said were welcome emphasised self-help and a participative approach to treatment decisions. Comprehensive '*one-stop-shop*' approaches to harm reduction and a range of health and social care services have also been said to be beneficial for women in similar settings (YWCA, 2002).

Throughout their narratives, it emerged that the women were experiencing different stages of their treatment. However, most had endured a disappointing cycle of relapse as they tried to quit heroin, and some linked this with antecedent mental health issues, or stressful past and present abusive circumstances. It has been recommended that treatment services for women drug users should routinely screen for depression and abuse, to promote optimum drug treatment outcomes (Blume, 1990; Boyd, 1993). Some of these traumas may require specialist counselling but occur so frequently within this client group that robust arrangements should be in place (McKeganey *et al*, 2005). Boyd (1993) has also advocated that strategies to cope with drug-using male partners should be included within women's care plans, and many interviewees said they linked relapse with a partner's dependence. It is possible that this approach would be helpful for the male partners too, since a few women admitted that they had affected their partners' drug use.

The majority of interviewees advanced a view that the influence of using heroin with a male partner had been to increase their consumption and drug dependence, and that there was often disparity in the couple's intention to become drug-free. Women spoke of efforts to quit heroin being sabotaged, sometimes intentionally by either partner, and most of them had terminated

relationships for this reason. Only one interviewee said she was confident that her addict relationship could sustain a drug-free future, and attributed this to shared outdoor activities, which were entirely separate from heroin-using circles. It was notable that only one woman said she was giving up heroin for the sake of her boyfriend, and this particular individual was unaware of her addiction.

For a few women, recurrent relapse had permitted some insight into the factors which were critical to a sustainable recovery. Along with dissociation from other drug-users and establishing new networks and activities, they acknowledged the need to appraise and address their own self-concept. Support was requested from helping agencies to empower women drug users to strive towards self-determination, and to enable training, and employability skills to contribute to this goal. In this venture they recognised that securing some kind of drug-free career could confer and replace the self-worth and social identity which had been derived from being an active heroin user. It is possible that, as with a legitimate career, the adoption of a particular role, whether as a trainee, volunteer or employee, might help to build self-confidence and stronger coping responses (Gossop *et al*, 2002a; McIntosh & McKeganey, 2001).

Loss of self-esteem and confidence was frequently mentioned and was often bound up in interviewees' own perceptions of a heroin-ravaged appearance, which had fulfilled the stereotype of the female drug user. Brief interventions in healthy lifestyle advice should be integral to good practice in health service provision, and the fore-mentioned peer mentors might also offer credible guidance and support. Community pharmacists were singled out as professionals who had often developed therapeutic relationships, and public health development, including lifestyle advice, is a component of the recently introduced contractual framework for pharmacies (DH, 2005b). Jones and colleagues (2004) have pointed out that these health professionals are easily accessible, and ideally situated to gain a sound understanding of local needs, and to improve the health of their neighbourhoods.

Recapture of the "old self", and perhaps even more importantly the person they now aspired to be, was already recognised by some interviewees as crucial to their strategy for sustainable recovery. In order to achieve this, interviewees asked for support to make the necessary stepped changes, and for reassurance

that it would be possible within their personal resources. Most of all they craved reassurance that there could be a drug-free life that was more rewarding than their current one seemed to be. They valued the drug treatment and support received from some local services, but in addition, asked to gain healing, courage and hope for the future.

## Chapter 8

### Conclusions: Findings, Implications and Recommendations

In conclusion, this chapter will begin by appraising the main research findings of this descriptive and analytic account of influences upon women's drug use in North Cumbria. The second section will highlight some of the key findings with implications and recommendations for policy and practice, and will indicate the limitations of the study as well as suggestions for future research.

#### Research findings

This study has allowed insight into the attitudes and beliefs of a sample of women drug users, and has provided a descriptive account, as well as an analysis of influences upon the initiation and continued development of their problematic drug use. In particular, it has expanded the argument which maintains that women drug users should not inevitably be seen as passive companions in addiction. Interviewees articulated their own choice in the decision to try heroin, departing from earlier definitions of immature individuals who are dependent upon and easily influenced by others: for example, described as '*pathetic, passive, psychologically or socially inadequate*' (Perry, 1979: 1). This previous casting of women drug users is therefore challenged in this thesis by the analysis of interviewees' narratives. Furthermore, the women elaborated the context of this drug-trying by describing a spectrum of influences which they believed had predisposed initiation, as well as other factors which were relevant to the course of their problem drug use. Interviewees' responses underlined the heterogeneity of women drug users and their experiences, but consistent themes have been identified and analysed in preceding chapters.

The theoretical concept of a '*career*' was employed both by Rosenbaum (1981a) and Taylor (1993) in their analyses of female addiction, and it has also provided a framework to guide interpretation of influences on women's drug use in North

Cumbria. The 'career' paradigm is less judgemental than many explanations of women's drug use, and has allowed interviewees to emerge as active participants who have made a choice (Ettorre & Riska, 1995; Taylor, 1993). It has also permitted addiction to be considered from the user's point of view, as a sequential process over time, much like any career in a legitimate field. A heroin user's lifestyle had conferred similar benefits such as: social contacts; collective purpose; skills development; self-esteem; status; and social identity. At each of the five stages of an addiction 'career': 'initiation; apprenticeship; maintenance of the addict identity; ambivalence'; and then 'conversion to abstinence' (Rosenbaum, 1981a), the data generated by this study has revealed findings which contribute to the evidence base on women and drug dependence.

The key findings and conclusions from this study in North Cumbria have been identified as the need to acknowledge: interviewees' declared agency in the decision to use heroin; their intention to seek pleasure from the heroin-using experience; their claims that certain predisposing factors might have made them susceptible to initiation; and their belief that a specific type of intervention could benefit other women drug users. These and other main findings will now be set out, using the framework of the five stages of their addiction 'career' (Rosenbaum, 1981a). The second section of this chapter will then discuss some of the implications and recommendations for policy and practice from the key research findings.

### **Initiation into problem drug use**

Interviewees continually asserted that they had been active players in initiating heroin use and denied that they had been coerced in any way. The importance of taking ownership of that decision to use heroin is a significant finding, since this can allow women drug users to emerge with dignity as agents in their own right, and not merely as the passive companions or victims of the drug culture, so often depicted previously (Cuskey, 1982; Gomberg, 1986; Marsh *et al*, 1986; Perry, 1979; Wellisch *et al*, 1970).

### **The pursuit of pleasure**

A further significant finding was that the decision to try heroin had often derived from curiosity about its effects, or as an apparent pathway to seek some fun or escape, although eventually many were trapped in a 'chaotic vicious circle' (Raine,

2001) feeling '*stigmatised, marginalized and demoralised*' (Ettorre, 2004). It can be argued that young men may have equivalent need to seek relief from boredom, but many interviewees went on to explain that their pleasure was linked with notions of casting off professed gender-based restrictions. This may be seen to resonate with the theoretical perspectives of Ettorre (1989; 1992; 2004), Henderson (1997; 1999) and Measham (2002), which link women's drug use with ideas of female emancipation. This finding is noteworthy because it may offer therapeutic professionals an opportunity to help women addicts to define for themselves some of the more positive aspects of heroin use, and then to explore equivalent but less harmful, sources of pleasure, excitement and independence. Moreover, this finding of independent pleasure-seeking endorses the notion of women as purposeful agents in their initiation.

### **Predisposing risk factors**

Furthermore, many women elaborated this claim by pointing out a number of predisposing influences upon their dependent drug use, which they believed had made them susceptible, although they still claimed responsibility. These included issues such as: grief and depression; loneliness; early experimentation with substances; truanting; public care; living in households with drug-using siblings or violence; or having been subjected to physical, emotional or sexual abuse. Interviewees often linked an accumulation of these risk factors with the inception of their problem drug use, and asserted that any residual mental distress could present a barrier to resolving their drug dependency. These adverse circumstances may equally apply to young men, but it has been argued that young women may experience more persistent and debilitating sequelae (Copeland & Hall, 1992; Holsten, 1985; Melrose & Brodie, 2000; Robbins, 1989). This finding of predisposing risk factors is important because it appears that the effectiveness of women's drug treatment can be seriously diminished unless any antecedent psychological problems have been properly addressed (Blume, 1990; Boyd, 1993).

### **The influence of the social context**

Underscoring these key findings about initiation, the influence of the social context was evident, as documented in the literature on the development of drug dependence (Bloor *et al*, 1993; Connors, 1992a; Kane, 1991; McKeganey & Barnard, 1992; Rhodes, 1997). The power of conformity was revealed in the

women's accounts and the decision to experiment was often influenced by group opinion, with friends sometimes becoming the conduit for the supply of drugs. Modelling the behaviour of friends or siblings was often recalled, demonstrating the effect of Social Learning (Bandura, 1961), and the importance of social interaction in the early stages of drug use. Interviewees often explained that becoming a drug user afforded a distinct social identity, which became part of the reward of participation. Conversely, it has been argued that peer influences may discourage illegal activities and protect against harmful health behaviours (Hawkins *et al*, 2002), but women in this study claimed that their social environment could influence early experimentation. Although heroin use often induced initial nausea, the women said that they had persevered and it became a rewarding experience which reinforced further use.

### **'Apprenticeship': learning addict skills**

As women moved on to an '*apprenticeship*' stage (Rosenbaum, 1981a) where '*regular visits are made into addict life*', it was often described as a time of fun and daring, and of developing links with a new '*social world*' of more exciting options (Rosenbaum, 1981a). This social environment brought interviewees into contact with many other drug users and nearly all of the women had established liaisons with experienced, often older, male addicts. Although admiration of his personal qualities was declared, several women intimated that this partner also had *cachet* as a heroin user, and could facilitate continued drug use. Some interviewees even admitted that better access to heroin had been a factor in their choice of partner.

There was common agreement that problem drug use was usually initiated in the company of a boyfriend, but none of the women countenanced any suggestion that he had forced her to use heroin. However, once heroin was used within a dyad, interviewees described increased drug dependence and '*inundation*'. It might equally be found that men's heroin use could increase when living with a female addict, and a few interviewees indicated that they had influenced novice partners in this way. It has been pointed out that a greater proportion of female drug users enter relationships with male counterparts (Davies *et al*, 1996; Gossop *et al*, 1994; McKeganey & Barnard, 1992), and the women's reports of escalating addiction may simply demonstrate the impact of daily proximity to a supply of heroin. Trusting a partner was claimed to be of

central importance to their relationship, and many women admitted that they had exposed themselves to risks of infection and disease by the custom and practice of intimacy.

***'Maintenance of an addict identity': developing drug dependence***

*'Maintenance of an addict identity'*, when women used heroin regularly and adopted the social identity of an addict, became a full-time occupation which required energy, commitment and resourcefulness (Rosenbaum, 1981a).

*'Careers'* often expanded into other criminal activity to secure funds to buy heroin, which affirmed the women as *'deviants'*. Other addicts soon became seen as *'significant others'*, although as *"associates"* rather than *"true friends"*. This heroin lifestyle, commonly shared with a male partner, was said to have become fraught with a spectrum of risks and these included: the development of addiction; transmission of blood-borne infection; a damaged reputation; criminality; loss of job; loss of family contact or child custody; and ultimately for some, the loss of their valued sexual relationship. Although many of these risks could apply equally to male counterparts, interviewees maintained that they perceived greater stigma and subsequent disadvantage as female addicts, because of conventional societal gender expectations (Ettorre, 1992; Rosenbaum, 1981a). Amongst a range of risks present in their drug-using lifestyle, health-related harm was said to be of lesser importance, and the majority of women made it clear that heroin and the security of valued sexual and social relationships invariably took precedence. Knowledge alone appeared to be insufficient to protect against infection, and the likelihood of blood-borne viral infection through injecting practices or sexual contact often seemed to be ignored or *'bracketed out'* (Giddens, 1991). On the other hand, additional risks to personal safety, from overdose or assault by other drug users, were believed to be mitigated by the *'cocoon'* (Giddens, 1991) of a sexual relationship.

It has been argued that in certain ways the non-urban setting can also serve to increase drug users' vulnerability to some of these risks since they may be more *'highly visible'* (Henderson, 1998), and the women made similar observations. As women drug users, some interviewees said they felt stigmatised and subject to greater public censure when using harm-reduction services such as needle-syringe exchanges or Supervised Methadone Consumption schemes (Rosenbaum, 1981a). Some interviewees therefore relied upon partners to obtain

sterile injecting supplies, thereby increasing dependence and risk (Barnard, 1993), or were discouraged from seeking treatment. Travelling distance to participating pharmacies was presented as inconvenient and expensive for some interviewees, who reported having to make daily return journeys of at least forty miles.

#### **'Ambivalence': the decisional balance about further heroin use**

Rosenbaum (1981a) described the next stage as a time when addicts saw heroin use as '*alternately functional and dysfunctional*' and interviewees described a situation of ambivalence and uncertainty. Eventually all of the women had come to the point of weighing up the costs and benefits of their addict lifestyle, recognising that it was no longer acceptable to be the person they had become. Sometimes this had been prompted by interaction with criminal justice agencies, bitter estrangement from their families of origin, or because caring for their children had been put into jeopardy by their heroin use. Often, interviewees simply declared that they were tired of the "*hassles*" and needed to retire from a seemingly endless cycle of securing the funds to use heroin. The pleasurable aspects of heroin euphoria had dissipated and now they were obliged to use the drug to feel "*normal*". Once accustomed to the heroin lifestyle, interviewees explained the losses involved in giving it up: social contacts, and in particular their relationship with a male addict; social status; sense of purpose; and activity to fill their time. Despite claims of desiring an end to drug dependence, it was explained that it was very difficult to resolve addiction, and interviewees described real and perceived barriers to entering and engaging with treatment services: only one interviewee could say that she no longer used heroin or prescribed substitute medication.

#### **'Conversion to abstinence': making a commitment to end heroin use**

This stage of the addiction '*career*' is said to be the point where ambivalence wanes and the addict is convinced that there is a need to quit heroin use and the associated lifestyle. Despite this commitment, many interviewees had suffered a disappointing cycle of treatment and relapse, but those few who had thus gained some insight into the process were keen to share their observations. Several women remarked upon ineffective attempts to cease heroin use for the sake of their children, or for their own anxious parents: none mentioned their addict partners in this context. Interviewees claimed that "*doing it for myself*" and

*"becoming the person that I now want to be"* was the essential component of 'readiness' (Rosenbaum & Murphy, 1984) to quit heroin, and rated this *self-concept* as the touchstone for a sustainable recovery and for regained self-respect (McIntosh & McKeganey, 2002).

In this desire and need for a positive self-concept, drug users are not exceptional, but self-confidence may have been diminished by choices perceived as deviant by society. The psychologist Maslow (1987) challenged the view of behaviour being the direct consequence of experiences, and promoted the theory of '*self-actualisation*'. He argued that all human beings have basic needs which may be portrayed in a hierarchy, and that beyond physical needs, individuals strive for self-esteem, derived from within as well as the opinion of others. When these positive factors are in place an individual is more likely to act with self-confidence, and be motivated towards self-determination. Some interviewees referred to interludes which had encouraged motivation, and provided examples of apparently trivial gestures of support from others, which had made an appreciable difference.

### **Interviewees' recommendations for service development**

While discussing their experience of treatment services, most of the women (22: 30) identified the need for a specific type of drug treatment intervention in North Cumbria, and this will now be highlighted as a final key finding. These interviewees asserted that a peer mentoring scheme delivered by local recovered women addicts could be beneficial, offering a range of supportive informal advice outside clinic sessions. Many women (20: 30) believed that they themselves would have the authentic experience, with suitable training, to provide such a complementary service. Interviewees claimed that the knowledge gained from episodes of relapse, and their own first-hand understanding could support and promote successful long-term recovery for other local women addicts. Several interviewees (15: 30) mentioned the isolation and despondency experienced by those attempting to dissociate from other drug users as part of their treatment plan. In that situation, they said that a reliable point of contact could encourage perseverance and help to avert relapse. This study needed to focus on the influences upon this sample of women drug users, but it might be found that male drug users in North Cumbria would find the introduction of a similar intervention equally beneficial.

Furthermore, the narratives of this study have provided an insight into the lived experiences of a sample of women drug users' initiation and development of problem drug use, as well as a glimpse of their current situation and tentative dreams of an ideal future. As sustenance towards this future, interviewees often asked for a sense of optimism to foster confidence in their ability to cast off this addict identity, and to establish fulfilling new lives in their own right. Interviewees' resilience and determination to try to resolve their dependence, often in the face of multiple disadvantages, deserves the most relevant support to help them and other women drug users to develop their full potential.

The following section will now discuss the implications and recommendations for policy and practice derived from these findings, and will then suggest a few topics for future research, which were prompted by this study.

### **Implications and Recommendations for policy, practice, and future research**

The implications of some of the key findings, along with recommendations for policy and practice, will now be considered. The mosaic of influences upon women's problem drug use implies that no single recommendation can be sufficient. The particular complexities presented mean that a multi-faceted approach may be most effective, including primary prevention work with young people. This study posed some additional questions which may stimulate further research and the final section will set out suggestions. However, the limitations of this qualitative study in North Cumbria include the following, and must now be acknowledged.

#### **Limitations**

Firstly, some critics assert that it is difficult to generalise from relatively small qualitative studies. On the other hand, it has been argued that any individual account is potentially meaningful and has validity since it is the product of its social domain, which can then be specifically analysed (Hollway, 1989). Women drug users are not a homogeneous group, wherever they may be located, but this study has considered and interpreted the differences and similarities presented

within interviewees' narratives. '*Grounded theory*' (Glaser & Strauss, 1967) which focusses upon the social context as well as the individual's role in social interaction, has been used to investigate experiences, along with any associated perceptions and thoughts. Constant comparison has allowed relevant ideas to develop from the data, which have been coded and categorized to generate the main concepts and themes of analysis of this study.

Secondly, the weighting of the sample towards established users who had come forward for treatment, is acknowledged as a limitation. It has been suggested that community-based samples may differ from those in treatment (Kline, 1996; Powis *et al*, 1996), and Wright (2002) has proposed that women may only overcome the barriers to accessing treatment when they experience severe difficulties. Despite this constraint, a range of stages in the treatment process, as well as life experiences, was portrayed: some women had begun to use heroin more than twenty years ago, others for less than two. Interviewees were recruited from throughout North Cumbria, aged between seventeen and forty-two, in a relationship or single; living in larger towns, small villages or on a farm. Only one was not White British, but in Cumbria Non-White individuals comprise only 0.7% of the local population (ONS, Census, 2001).

It is known that women's drug use tends to be more covert, described by Rosenbaum (1981a) as '*relative secrecy*', and that they can often be difficult to access for interview or treatment. Lee (1993: 60) explains that '*the less visible an activity is the harder it is to sample*', and this study is indicative rather than representative in any statistical sense. Gaining access to women who were willing to be identified as drug users presented significant difficulties, and therefore interviewees were mainly recruited through treatment agencies or social care organisations in both the statutory and voluntary sector.

A final factor to highlight is the potential for recollections of early stages of drug use to be influenced by current patterns, as well as the perceptions of therapeutic professionals (McIntosh & McKegancy, 2000). Retrospective experience is likely to differ from the temporal because the social context in which it is embedded is probably at variance (Mansfield & Collard, 1988). Nevertheless, in this study in North Cumbria, there was a high degree of consistency in the main themes of analysis, although these were derived from a

variety of life experiences. The findings of this study acknowledge some limiting constraints, but increased understanding of women's drug use may still be extrapolated.

### **Implications and Recommendations**

This section will set out the implications for policy and practice of the key findings of this study. Those selected include: the influences upon initiation; the need for gender-sensitive assessment; and the need identified for a specific type of service development, which was suggested by interviewees themselves. It is both politically expedient and pragmatic that service users, the women who have the lived experience of drug dependence, also have the opportunity to voice their opinions on essential and effective features of treatment interventions, and thus to shape local drug treatment services.

#### **Influences upon initiation**

In the first instance, a key implication derives from the finding that women drug users in this study were active participants in their addict '*careers*', challenging a common perception that they have been introduced to heroin by male partners (Cuskey 1982; Eldred & Washington, 1976; Parker *et al*, 1988; Reed, 1985; Suffet & Brotman, 1976). It seemed that it is erroneous to view them as mere victims of the drug culture, since interviewees often said that they had chosen to use heroin from curiosity or to seek new experiences. In addition, many women claimed that they had developed a social identity, along with an initial sense of empowerment from this venture. The recognition of individuals who had decided to try heroin for their own pleasure may confer the dignity of agency, and may allow therapeutic practitioners to help women drug users to identify less harmful options for diversion and fun.

In North Cumbria, it seemed that a fascination with heroin and the prospect of excitement or fun prevailed, and virtually every woman said she had initially enjoyed its use, both the pharmacological effect and the thrill of the '*life*', claiming that this had relieved boredom. This '*felicity principle*', influencing decisions to use substances deemed '*disreputable pleasures*', has been expounded by O'Malley and Valverde (2004), who note its general absence in harm-reduction discourses, and many women recalled and tried to describe heroin's unique sensations of euphoria.

The pursuit of pleasure will undoubtedly be common to women in all types of location but interviewees in North Cumbria often lamented the lack of affordable sophisticated entertainment. The specific impact upon young women of this type of environmental factor has been documented in a recent report (YWCA, 2002). In particular, public transport and leisure opportunities can be more limited in a non-urban setting (Henderson, 1998; Mentor UK, 2004; YWCA, 2002) and Ettorre (1989: 109) has declared that *'women's investigation of pleasure is intrinsically related to, if not determined by, their specific material circumstances'*. She has argued that young women must be encouraged to explore *'adventurous leisure'*, which can safely satisfy a need for risk, as well as extend traditional gender stereotypes (Ettorre, 2004). Young women must therefore be effectively supported and empowered to explore diversionary activities and less destructive options than engaging in substance misuse.

#### **The need for gender-sensitive assessment**

A further implication arises from the finding that a number of interviewees had experienced a range of abusive and traumatic events, often linking these with their susceptibility to problem drug use. It may now be more helpful and empowering to regard them as *'survivors'* of these episodes of profound distress or victimisation (Hague & Malos, 1998). Self-determination and the motivation to develop a non-drug-user identity will need the self-confidence to take back control of their own lives, given the financial, material and emotional resources to do so. Some interviewees asked for specialised professional counselling to be made available to help them to resolve remaining issues, thus enabling the women to move on with their future lives, and this should be addressed.

This prevalence of this specific vulnerability among female drug users has already been observed (Broom, 1994; McKeganey *et al*, 2005; Roth, 1991; Swift *et al*, 1996; Vogt, 1998; Wilson, 1997), but in North Cumbria specialist services can often be widely dispersed, with access problems increased by rural isolation and sometimes magnified by women's care responsibilities. In particular, domestic abuse had affected nearly half of the sample, but none was aware of local support services, nor believed that she would be well-received as a drug user. Joint protocols between women's crisis and substance misuse services should be developed, as well as appropriate specialist training for drug agencies

to assess, support or refer survivors of violence (McKeganey *et al*, 2005). Recent good practice guidelines which recommend collaborative working between domestic abuse and substance misuse services should also be disseminated to optimise treatment outcomes (Stella Project, 2004).

Given the higher prevalence of mental distress and disorder; eating disorders; self-mutilation; childhood sexual, physical or emotional abuse; unresolved grief; and post-traumatic stress reported to affect women drug users (Broom, 1994; McKeganey *et al*, 2005; Roth, 1991; Swift *et al*, 1996; Vogt, 1998), it has been argued that it is vital that assessment take place at an early stage in treatment (Blume, 1990; Boyd, 1993). Left unresolved, it has been said that these issues will diminish the effectiveness of treatment (Blume, 1990; Boyd, 1993), and a counsellor skilled in the necessary specialist work should be made available to address similar concerns (McKeganey *et al*, 2005). Psychosocial interventions such as cognitive behavioural therapy (CBT) can also have a significant effect on underlying mental health problems, as well as an individual's drug misuse (Wanigaratne *et al*, 2005). Confidence-building techniques, as well as interventions which look holistically at health and social problems may be efficacious in helping to develop women's self-determination (Hague & Malos, 1998). Assertiveness skills may also support individuals to recover or redefine their sense of self, and should become part of the repertoire of treatment.

It is therefore argued that gender-sensitivity to specific issues which may be influential on drug dependence is essential to avoid intensifying feelings of failure about any relapsing behaviour by those who have already suffered disadvantage. It may equally be found that some particular issues are more relevant for male drug users and it is therefore implied that gender-sensitivity in assessment is required, recognizing difference but avoiding stereotypical gender assumptions (Neale, 2004). Any gender variations may not only influence the likelihood of seeking treatment, but may also determine the range of treatments which are both accessible and acceptable.

Health and social care modernisation should include gender-sensitivity in quality assurance frameworks and in staff training (Doyal *et al*, 2003), as well as the integration of existing support for vulnerable people of all ages. Broom (1995: 414) has asserted that '*Gender is not an optional extra that should be considered*

once the 'real' causes of drug abuse have been addressed, nor is it a luxury to be left until funding is more generous. For the health and well-being of men and women alike, gender must be taken seriously by all those who are serious about understanding drugs, and the relationship of drugs to people's lives and health'.

### **Interviewees' suggestion for a specific type of service development**

Following on from this last assertion, a final implication concerns the provision of specific women's services, which is often advocated, and for those with a history of male victimization, this may certainly be preferable (Becker & Duffy, 2002; Broom, 1994; Burman, 1992; Hodgins *et al*, 1997, NTA, 2002). A number of studies indicate that women-only services can attract and retain drug users in treatment, and a superior outcome has often been claimed (Copeland & Hall, 1992b; Copeland *et al*, 1993; Dahlgren & Willander, 1989). Traditional group work for drug treatment has been said to disadvantage women, since they are always outnumbered and sometimes intimidated (Powis, 1995), or unable to discuss personal issues (Hodgins *et al*, 1997), and may even feel unsafe (Copeland *et al*, 1992). Furthermore, Schliebner (1994) has argued that women in mixed groups tend to nurture men's needs to the detriment of their own progress. One study of male and female interactions found that males tended to dominate conversations, and mixed groups may therefore exclude many women from equal and effective participation (Fishman, 1990). In commenting on this deference to male social power, she pointed out that *'The women seemed to try more often and succeeded less often than the males. The men tried less often and succeeded more often'* (Fishman, 1990: 233).

On the other hand, from a feminist perspective, Ettorre (1989) has commented that women-orientated groups can create a powerful dynamic to help women re-affirm their identities and to reject all that has defined them as addicts. She has referred to Vance's (1984: 24) statement that *'it is not enough to move women away from danger and oppression: it is necessary to move towards pleasure, agency, self-definition'*. Ettorre (1989) goes on to argue that the very fact that women drug users are seen by society to be *'polluted'* gives them a unique ability to mobilise their own personal power and potentially, collective power. Furthermore, it has been claimed that there is a need to move women away from replacing heroin addiction with dependency on drug workers or therapy, since self-determination should be encouraged (Schliebner, 1994). Therefore it seems

that, more than simply offering protection, some women-only groups may be able to foster the confidence to renew self-concept, and to resist the oppression and disadvantage which has often circumscribed their problem drug use.

In North Cumbria, much of the substance misuse treatment for problem drug use is delivered as Shared Care in collaboration with GPs, which can increase access to health services for many women. This is particularly relevant during pregnancy, although a specialist midwife liaison project could further enhance service provision at this time, when many women initiate help-seeking and try to modify their drug use (Clark & Formby, 2000). Day care services and a Service Users' Group were under development at the time of this study, but recruitment of women to the sessions had been very limited. Treatment agencies reflected concerns which were similar to those already mentioned, such as the women's anxiety about being identified as drug users, and of male partners discouraging women's attendance for fear of them breaching confidentiality.

None of the women in this study had ever attended a group session as part of their drug treatment, and thus felt unable to pass comment on this type of service delivery. A few (4: 30) interviewees mentioned feelings of being oppressed by male drug-dealers if they waited in a mixed group at the drug agency, but for those attending GP surgeries this did not predominate. However, many interviewees (19: 30) were keen to undertake courses on topics ranging from the basic skills of literacy and numeracy, to social skills and assertiveness. If women-only group work were ever to be developed, offering it as a course and linking it with skills development might be more attractive, and raise fewer concerns for male partners. Some interviewees (15: 30) made suggestions for the type of topics an ideal course might contain and these included: alternative therapies; relaxation; parenting skills; and healthy lifestyles, including budgeting and benefits advice.

However, in preference to a group, most interviewees (22: 30) responded that some type of women's peer support would enhance service provision in North Cumbria. Hanke and Faupel (1993) have already argued that mixed groups tend to lack positive female role models, and that mentoring can be an important part of resolving women's addiction. Moreover, Mondanaro (1987) has pointed out that '*natural helpers*' or peer leaders can complement formal service provision,

and can empower women by involving them in the planning and delivery of the intervention (Mondanaro, 1990). A recent YWCA (2002) report has commented that for socially excluded young women in more rural areas a telephone support scheme would be beneficial, and this could be utilised for a mentor project.

In this study in North Cumbria, it was proposed that mentoring could: reduce isolation; provide informal support; and importantly, provide encouragement and an exemplar that successful recovery from addiction might be possible.

Unanimously, these interviewees believed that a recovered woman addict would be the most credible mentor, and many expressed a desire to help others women drug users in a similar predicament, once abstinence had been achieved. They all rated first-hand experience as authentic and invaluable at this time, and definitely preferable to that of "*booklearners who could never really understand*". It might be found that their male counterparts would welcome a similar intervention, but this study was committed to describe the influences on this sample of women drug users.

It has been remarked that improved quality of life may not be immediately evident for those in drug treatment, and that any benefit may take six months to emerge (Ghodse *et al*, 2003). One study determined that the most salient quality of life issues for drug users undergoing treatment were improved health, housing and finances (Brogly, 2003), whilst another found that despondency and negative emotions were a strong predictor of drug relapse (Graham *et al*, 1999). It may be surmised that appropriate mentor support during and after drug treatment could be a cost-effective means of improving retention and ultimately outcomes, and should be considered in service development for North Cumbria.

Training programmes for these mentors could include: communication skills; relapse and overdose prevention; as well as simple advice on lifestyle issues such as: balanced eating; physical activity; alcohol; smoking; and stress management. This approach resonates with the Health Trainer model (DH, 2004c), and could also respond effectively to issues that interviewees had raised about improving their personal appearance. This initiative could help to increase women drug users' confidence to rebuild social networks, or to consider applications for training and employment.

## Indications for future research

A future study in North Cumbria could use a participative action research approach to determine whether the fore-mentioned type of mentor intervention might benefit treatment uptake, retention and completion for a group which has been established to be '*harder to reach*', and thus seldom heard. There is a need to understand more about the processes which underpin local women's successful recovery from addiction, as well as greater sensitivity to the stages in their addiction '*careers*'. This proposed study could establish whether or which of the specific elements of building self-esteem, self-determination and resisting oppression may be effective. If women can be encouraged to believe that relapse does not necessarily mean failure, that recovery is possible and that opportunity may await, there may be a better chance to improve the outcomes of their treatment for drug dependence.

A second suggestion derives from the comments made by several interviewees about the need for drug services to receive them with greater optimism about recovery. Recent reports (Audit Commission, 2004) have recommended that long-term maintenance in addiction treatment is not acceptable, and that services should seek an objective of abstinence for their clients, even if this is a gradual process. In order to support women in the belief that their dependence is reversible, and that improved circumstances may be the outcome, it seems essential that those treating and supporting them are convinced of this ethos. A future study could explore the attitudes and beliefs of those professionals who are supporting and advising women about their addiction, to establish whether any negative opinions about outcomes may be retained. As an illustration, a few women provided examples of situations where they believed they had been patronized or treated unfairly, and Goode (2000) has noted that some female staff may unconsciously dismiss and blame those, particularly mothers, who are expected to be the '*copers*' (Graham, 1982). In this particular instance, it seems vital to dispel stereotypes of passive individuals who have been oppressed into drug dependence. Women in this study asked primarily for reassurance that enduring abstinence could be possible, and for support from treatment agencies to help them to conceptualise, and eventually to realise it.

Finally, it seems essential for further research to investigate the male perspective on the influences on women's drug use, particularly that of their sexual partners. A complementary study could further illuminate the findings of this

work, and provide check and balance to the women's accounts. Research into male drug users' views of women's initiation into problem drug use, could examine any risks involved in their shared habit, as well as their perspective on any additional influences upon continued dependence for either partner within a drug-using social milieu.

## Interview Topic Guide

### **Relationship**

Single or not; whether married; how long together; how would you describe him/her; is partner a drug user or not; would you use if s/he wasn't around for any reason?

### **Drugs**

When did drug use begin; did anyone influence you to try; what kind of drugs have you used, are using; method of use; can you describe the last time when you used; ever shared equipment - with partner or anyone else; what does your partner think of your drug use?

### **Obtaining drugs**

Who gets hold of them; do you ever get them; if you go to the dealer, how does that make you feel; do you ever feel vulnerable or intimidated; how do you share out the drugs; does who gets them affect how you divide them up; do you use together or not; how do you decide what happens?

### **Harm reduction**

Do you think about any risks you might be taking. HIV, Hep C, have you seen/heard much about them; do you know anyone who has been affected; how do you manage risks; do you use the needle exchange; at the pharmacy or get them anywhere else; can you describe what it was like getting the needles; how did you feel about that; was there any difficulty - embarrassment; has anyone discussed sexual health; do you use condoms; how else do you manage any risks; do you discuss risks with your partner?

### **Treatment Services**

What stage would you say you were at; ever relapsed; do you remember the first time you went; how did you feel about that; how do you get to your appointment; what does your partner/family think - supportive or not; what has made a difference?

### **Family / Social Support**

Any children; any supportive family; do any of your friends/family use drugs; are you in secure accommodation?

### **Work/Training**

Have you a current job / or in Training; or at any time; what kind of work / training; how important is that to you, or your partner; how did you get on at school; any other interests or hobbies or plans for the future?

## References

- Aalto, E. & MacRae, R. (1997) *Risk taking and Risk Management Amongst Female Injecting Drug Users and Drug Injecting Couples. Final Report*. Edinburgh: The Scottish Office.
- Abbott, A.A. (1994) A Feminist approach to substance-abuse treatment and service delivery, *Social Work in Health Care*, 19: 67-83.
- Abdul-Quader, A., Quan, V. & O'Reilly, K. (1999) A Tale of Two Cities: HIV Risk Behaviours Among IDUs in Hanoi and Ho Chi Minh City, Vietnam, *Drug and Alcohol Review*, 18, 4: 401-407.
- Advisory Council on the Misuse of Drugs (ACMD) (1988) *AIDS and drug misuse Part 1*. London: HMSO.
- Advisory Council on the Misuse of Drugs (ACMD) (1998) *Drug Misuse and the Environment*. London: Home Office.
- Advisory Council on the Misuse of Drugs (ACMD) (2000) *Reducing drug-related deaths*. London: The Stationery Office.
- Advisory Council on the Misuse of Drugs (ACMD) (2003) *Hidden Harm: Responding to the needs of children of problem drug users*, p.21. London: Home Office.
- Aldridge, J., Parker, H. & Measham, F. (1999) *Drug trying and drug use across adolescence: a longitudinal study of young people's drug taking in two regions of Northern England*. Research Paper 1. London: Home Office.
- Alison, L. (2000) What are the risks to children of parental substance misuse? In H. Harbin. & M. Murphy. (eds.) *Substance Misuse and Childcare: how to understand, assist and intervene when drugs affect parenting*. Lyme Regis: Russell House.
- Allen, M. (2003) *Into the mainstream: care leavers entering work, education and training*. York: Joseph Rowntree Foundation.
- Almog, Y.J., Anglin, M.D. & Fisher, D.G. (1993) Alcohol and heroin use patterns of narcotic addicts: gender and ethnic differences, *American Journal of Drug and Alcohol Abuse*, 19, 2: 219-238.
- Amaro, H. (1995) Love, Sex and Power: Considering Women's Realities in HIV Prevention, *American Psychology*, 50, 6: 437-447.
- Anglin, D., Hser, Y. & McGothlin, W. (1987) Sex differences in addict careers. 2: Becoming addicted, *American Journal of Drug and Alcohol Abuse*, 13: 59-71.
- Anglin, M.D., Hser, I. & Grella, C.E. (1997) Drug addiction and treatment careers among clients in the Drug Abuse Treatment Outcome Study (DATOS), *Psychology of Addictive Behaviors*, 11, 4: 308-323.

- Ary, D., Duncan, T., Duncan, S. & Hops, H. (1999) Adolescent problem behaviour: the influence of parents and peers, *Behaviour Research and Therapeutics*, 37, 3: 217-230.
- Ashton, M. & Witton, J. (2004) *Methadone dose and methadone maintenance treatment. Research into Practice* 3. London: National Treatment Agency.
- Audit Commission (2002) *Changing Habits: the commissioning and management of community drug treatment for adults*. London: The Audit Commission.
- Audit Commission (2004) *Drug misuse 2004: Reducing the local impact*. London: The Audit Commission.
- Aust, R. & Condon, J. (2003) *Geographical variations in drug use: Key findings from the British Crime Survey*. Home Office Statistical Bulletin 15/03. London: Home Office.
- Bahr, S., Hawks, R. & Wang, G. (2003) Family and religious influences on adolescent substance abuse, *Youth and Society*, 24: 443-465.
- Bajos, N. (1997) Social factors and the process of risk construction in HIV sexual transmission, *AIDS Care*, 9, 2: 227-237.
- Balding, J. (2004) *Young People in Cumbria in 2003*. Exeter: Schools Health Education Unit.
- Bancroft, A., Carty, A., Cunningham-Burley, S. & Backett-Milburn, K. (2002) *Support for the families of Drug Users: A Review of the Literature*. Edinburgh: Scottish Executive, Effective Interventions Unit.
- Bandura, A., Ross, D. & Ross, S. (1961) Transmission of aggression through imitation of aggressive models, *Journal of Abnormal and Social Psychology*, 63: 575-582.
- Banwell, C, Denton, B. & Bammer, G. (2002) Programmes for children of illicit drug using parents: issues and dilemmas, *Drug and Alcohol Review*, 21: 381-386.
- Barnard, M.A. (1992) *Gender differences in HIV Related Risk Behaviour in a sample of Glasgow drug injectors*. Public Health Research Unit: University of Glasgow Press.
- Barnard, M.A. (1993) Needle-sharing in context: Patterns of sharing among men and women injectors and HIV risks, *Addiction*, 88, 6: 805-812.
- Barnard, M.A. (1999) Forbidden questions: drug dependent parents and the welfare of their children, *Addiction*, 94, 9: 1109-1111.
- Barnard, M.A. (2001) *Intervening with drug dependent parents and their children: what is the problem and what is being done to help?* Centre for Drug Misuse Research: University of Glasgow.

Barnard, M., & McKeganey, N. (2004) The impact of parental problem drug use in children: what is the problem and what can be done to help? *Addiction*, 99, 5: 552-559.

Barnett, O.W. & Fagan, R.W. (1993) Alcohol abuse in male spouse abusers and their female partners, *Journal of Family Violence*, 8, 1: 1-25.

Barnish, M. (2004) *Domestic Violence: A Literature Review*. London: Her Majesty's Inspectorate of Probation.

Bartky, S.L. (1988) Foucault, femininity, and the modernization of patriarchal power. In I. Diamond & L. Quinet (eds.) *Feminism and Foucault: Reflections on Resistance*. Boston: Northeastern University Press.

Bate, E. (2005) A investigation into the health and social needs of women who use illicit drugs, *Journal of Community Nursing*, 19, 4: 24-28.

Bate, E. & Leggate, J. (2003) Maternal health and Drug Abuse in the United Kingdom: Fife, Scotland. In (eds.) Baldacchino, A., Riglietta, M., Corkery, J. *Maternal Health and Drug Abuse: Perspectives Across Europe. Monograph Series 3*. Ringkobing, Denmark: ECCAS (European Collaborating Centres in Addiction Studies).

Bauld, L., Butler, R., Hay, G. & McKeganey, N. (2004) *Drug prevention for young people in England: Final report*. London: Department of Health.

Bays, J. (1990) Substance misuse and child abuse: impact of addiction on the child, *Paediatric Clinics of North America*, 37, 4: 881-904.

Becker, H. (1953) Becoming a Marijuana User, *American Journal of Sociology*, 59: 235-242.

Becker, H. (1963) *Outsiders: Studies in the Sociology of Deviance*. New York: Free Press.

Becker, J. & Duffy, C. (2002) *Women drug users and drugs service provision: Service-level responses to engagement and retention*. London: Home Office.

Beckett, H., Heap, J., McArdle, A., Gilvarry, E., Christian, J., Bloor, R., Crome, H. & Frischer, M. (2004) Understanding problem drug use among young people accessing drug services: a multivariate approach using statistical modelling techniques. *Home Office Online Report 15/04*. London: Home Office.

Beeching, N.J. & Crowcroft, N.S. (2005) Tetanus in injecting drug users, *British Medical Journal*, 330, 7485: 208-209.

Bekir, P., McLellan, T., Childress, A.R. & Garth, P. (1993) Role reversals in families of substance misusers: A trans-generational phenomenon, *International Journal of the Addictions*, 28, 7: 613-630.

Bell, C. & Newby, H. (1976) Husbands and Wives: The Dynamic of the Deferential Dialectic. In Barker, D.L. and Allen, S. (eds.) *Dependence and Exploitation in Work and Marriage*. London: Longman.

Bell, D.C., Montoya, I.D. & Atkinson, J.S. (1997) Therapeutic connection and client progress in drug abuse treatment, *Journal of Clinical Psychology*, 53, 3: 215-224.

Bellis, M.A., Beynon, C., Millar, T. Ashton, J.R., Thomson, T., Djuretic, T. & Taylor, A. (2001) Unexplained illness and deaths among injecting drug users in England: a case control study using regional drug misuse databases, *Journal of Epidemiology and Community Health*, 55: 843-844.

Bennett, L. & Lawson, M. (1994) Barriers to cooperation between domestic violence and substance abuse programs, *Families in Society*, 75, 5: 277- 286.

Bennett, G.A., Velleman, R.D., Barter, G. & Bradbury, C. (2000a) Gender differences in sharing injecting equipment by drug users in England, *AIDS Care*, 12, 1: 77-87.

Bennett, G.A., Velleman, R.D., Barter, G. & Bradbury, C. (2000b) Low autonomy in injecting is a risk factor for sharing injecting equipment, *Addiction Research*, 8, 1: 81-93.

Benney, M. & Hughes, E. (1984) Of sociology and the interview. In M. Bulmer (ed.) *Sociological Research Methods*, 2<sup>nd</sup> edition. London: Macmillan.

Berger, P.L. & Luckman, T. (1966) *The social construction of knowledge*. London: Penguin.

Best, D. & Abdulrahim, D. (2005) *Women in treatment services*, Research Briefing: 6. London: National Treatment Agency.

Beynon, C., Bellis, M., Millar, T., Meier, P., Thompson, R. & Mackway, K. (2001) Hidden need for drug treatment services: Measuring levels of problematic use in the North West of England, *Journal of Public Health Medicine*, 23, 4: 286-291.

Biernacki, P. (1986) *Pathways from heroin addiction: recovery without treatment*. Philadelphia: Temple University Press.

Biernacki, P. & Waldorf, G. (1981) Snowball sampling: problems and techniques of chain referral sampling, *Sociological Methods and Research*, 10, 2: 141-163.

Blair, C.S. & Hayes, P.C. (1997) Hepatitis C: Current concepts, *Proceedings of the Royal College of Physicians Edinburgh*, 27, 3: 300-310.

Bloor, M. (1995) *The Sociology of HIV Transmission*. London: Sage.

Bloor, M., Barnard, M., Finlay, A. & McKeganey, N. (1993) HIV-related risk practices among Glasgow male prostitutes: Reframing concepts of 'risk behaviour', *Medical Anthropology Quarterly*, 7, 2: 152-169.

Bloor, M., McKeganey, N., Finlay, A. & Barnard, M. (1992) The inappropriateness of psycho-social models of risk behaviour to understanding HIV-related risk behaviour among Glasgow male prostitutes, *AIDS Care*, 4, 2: 131-137.

Blume, S.B. (1990) Chemical dependency in women: important issues, *American Journal of Drug and Alcohol Abuse*, 16: 297-307.

- Borkowski, M., Murch, M. & Walker, V. (1983) *Marital Violence: The Community Response*. Tavistock: London.
- Bourgois, P. (1995) *In Search of Respect: selling crack in El Barrio*. Cambridge, New York: Cambridge University Press.
- Bourgois, P., Lettiere, M. & Quesada, J. (1997) Social misery and the sanctions of substance abuse: confronting HIV risk among homeless heroin addicts in San Francisco, *Social Problems*, 44, 2: 155-173.
- Bowling, A. (2002) *Research Methods in Health: Investigating Health and Health Services*. Buckingham: Open University Press.
- Boyd, C.J. (1993) The antecedents of women's crack cocaine abuse: family substance abuse, sexual abuse, depression and illicit drug use, *Journal of Substance Abuse Treatment*, 10, 5: 433-438.
- Boyd, C. & Guthrie, B. (1996) Women, their significant others and crack-cocaine, *The American Journal on Addictions*, 5, 2: 156-166.
- Boyd, S. (1999) *Mothers and Illicit Drugs: transcending the myths*. Canada: University of Toronto Press.
- Boys, A., Marsden, K., Griffiths, P. Fountain, J. & Strang, J. (1999) Substance use among young people: the relationship between perceived functions and intentions, *Addiction*, 94, 7: 1043-1050.
- Brogly, S., Mercier, C., Bruneau, J., Palepu, A. & Franco, E. (2003) Towards more effective public health programming for injection drug users: development and evaluation of the Injection Drug User Quality of Life Scale, *Substance Use & Misuse*, 38, 7: 965-992.
- Broom, D. (1994) *Double Bind: Women affected by Alcohol and other Drugs*. St Leonard's NSW: Allen and Unwin.
- Broom, D. & Stevens, A. (1991) Doubly deviant: women using alcohol and other drugs, *International Journal of Drug Policy*, 2, 4: 25-27.
- Broom, S.B. (1995) Rethinking gender and drugs, *Drug and Alcohol Review*, 14, 4: 411-415.
- Brown, G. & Harris, T. (1978) *The Social Origins of Depression*. London: Tavistock.
- Brown, L.S., Alterman, A.L., Rutherford, M.J., Cacciola, J.S., Zaballero, A.R. (1993) Addiction severity index scores of four racial and gender groups of methadone maintenance patients, *Journal of Substance Abuse*, 5, 3: 269-279.
- Brown, W., Mishra, G., Kenardy, J. & Dobson, A. (2000) Relationship between body mass index and well-being in young Australian women, *International Journal of Obesity*, 24, 10: 1360-1368.

- Burgess, R. (1984) *In the Field: An Introduction to Field Research*. London: Allen and Unwin.
- Burman, E. (1992) Feminism and discourse in developmental psychology: Power, subjectivity and interpretation, *Feminism & Psychology*, 2, 1: 45-60.
- Burns, W.J. & Burns, K.A. (1988) Parenting dysfunction in chemically dependent women. In I.J. Chasnoff (ed.) *Drugs, Alcohol, Pregnancy and Parenting*. Dordrecht: Kluwer Academic.
- Bury, J. (1992) Education and the Prevention of HIV infection. In Bury, J., Morrison, V. & McLachlan, S. (eds.) *Working with Women and AIDS: Medical, Social and Counselling issues*. London: Tavistock Routledge.
- Butler, T.G., Dolan, K.A., Ferson, M.J., McGuinness, L.M., Brown, P.R. & Robertson, P.W. (1997) Hepatitis B and C in New South Wales prisons: prevalence and risk factors, *Medical Journal of Australia*, 166: 127-130.
- Calsyn, D.A., Saxon, A.J., Freeman, G. & Whittaker, S. (1991) Needle-use practices among intravenous drug users in an area where needle purchase is legal, *AIDS*, 5, 2: 187-193.
- Campbell, J.C. (2002) Health consequences of intimate partner violence, *The Lancet*, 38090:1331-1336.
- Campbell, N. (1999) Regulating 'maternal instinct': governing mentalities of late twentieth century U.S illicit drug policy, *Signs: Journal of Women in Culture and Society*, 24, 4: 895-923.
- Canning, U., Millward, L., Raj, T. & Warm D. (2004) *Drug use prevention among young people: a review of reviews*. London: Health Development Agency.
- Canny, A. (2004) What employers want and what employers do: Cumbrian employers recruitment, assessment and provision of education/learning opportunities for their young workers, *Journal of Education and Work*, 17, 4: 495-513.
- Carlson, R (1996) The political economy of AIDS among drug users in the United States, *American Anthropologist*, 98, 2: 266-278.
- Carlson, R. (2000) Shooting galleries, dope houses and injection doctors: examining the social ecology of HIV risk behaviours among drug injectors in Dayton, Ohio, *Human Organisation*, 59, 3: 325-333.
- Carruthers, S. (2003) The ins and outs of injection in Western Australia, *Journal of Substance Use* 8, 1: 11-18.
- Carstairs, V. & Morris, R. (1991) *Deprivation and Health in Scotland*. Aberdeen: Aberdeen University Press.
- Cassell, M.M, Halperin, D.T., Shelton, J.D. & Stanton, D. (2006) Risk compensation: the Achilles' heel of innovations in HIV prevention? *British Medical Journal*, 332, 7541: 605-607.

Cawson, P., Wattam, C., Brooker, S. (2000) *Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect*. London: National Society for the Prevention of Cruelty to Children.

Chasnoff, I.J. (1991) Drugs, alcohol, pregnancy, and the neonate. Pay now or pay later, *Journal of the American Medical Association*, 18, 266 (11): 1521-1526.

Chassin, L., Potts, S.C. & Prost, J. (2002) Binge drinking trajectories from adolescence to emerging adulthood in a high-risk sample: predictors and substance abuse outcomes, *Journal of Consulting and Clinical Psychology*, 70, 1: 67-78.

Chavkin, W. (1991) Mandatory treatment for drug use during pregnancy, *Journal of the American Medical Association*, 266: 1556-1561.

Chivite-Matthews, N., Richardson, A., O'Shea, J. *et al* (2005) Drug Misuse Declared: Findings from the 2003/04 British Crime Survey. Home Office Statistical Bulletin. London: Home Office.

Chodorow, N. (1971) *Being and Doing: A cross-cultural examination of the socialization of males and females*. In V. Gornick & B. Moran (eds.) *Women in Sexist Society*. New York: Basic Books.

Chodorow, N. (1978) *The Reproduction of Mothering*. University of California Press: Berkeley.

Christo, G. (1998) A review of reasons for using or not using drugs: commonalities between sociological and clinical perspectives, *Drugs: Education, Prevention and Policy*, 5, 1: 59-72.

Clarke, K. (1999) Putting women first on the agenda, *Druglink*, 14, 5: 11.

Clarke, K. & Formby, J. (2000) Feeling good: doing fine, *Druglink*, 15, 5: 10-13.

Cleaver, H., Unwell, I., & Aldgate, J. (1999) *Children's needs, parenting capacity: The impact of parental mental illness, problem alcohol and drug use and domestic violence on children's development*. London: The Stationery Office.

Coleman, L. & Cater, S. (2005) *Underage 'risky' drinking: Motivations and outcomes*. York: Joseph Rowntree Foundation.

Coleman, R. & Cassell, D. (1995) Parents who misuse drugs and alcohol. In Reder, P. & Lucey, C. (eds.) *Assessment of parenting: Psychiatric and psychological contributions*. London: Routledge.

Connell, R.W. (1987) *Gender and Power: society, the person and sexual politics*. Stanford: Stanford University Press.

Connors, J. (1990) Women, drug control and the law, *Bulletin on Narcotics*, 42, 1: 41-47.

Connors, M. (1992a) Risk perception, risk taking and risk management among injecting drug users: implications for HIV prevention, *Social Science and Medicine*, 34, 6: 591-601.

- Connors, M. (1992b) Stories of pain and the problem of AIDS prevention: injection drug withdrawal and its effects on risk behaviour, *Medical Anthropology Quarterly*, 8, 1: 47-68.
- Cook, P.A., Downing, J., Hunt, G., Syed, Q. & Bellis, M. A. (2003) *HIV and AIDS in the North West of England 2002*. Liverpool: Liverpool John Moores University.
- Copeland, J. (1997) A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours, *Journal of Substance Abuse Treatment*, 14, 2: 183-190.
- Copeland, J. & Hall, A. (1992) A comparison of women seeking drug and alcohol treatment in a specialist women's and two mixed sex treatment services, *British Journal of Addiction*, 87, 9: 1293-1302.
- Copeland, J., Hall, W., Didcott, R. & Biggs, V. (1993) A comparison of specialist women's alcohol and other drug treatment services with two traditional mixed-sex services: Client characteristics and treatment outcome, *Drug and Alcohol Dependency*, 32, 1: 81-92.
- Copello, A. & Orford, J. (2002) Addiction and the family: Is it time for services to take notice of the evidence?, *Addiction*, 97, 11: 1361-1363.
- Coutinho, R.A. (1998) HIV and Hepatitis C among injecting drug users, *British Medical Journal*, 317, 7156: 424-425.
- Cowan, P.C. & Cowan, P.A. (1995) Interventions to ease the transition to motherhood: Why are they needed and what can they do? *Family Relations*, 44, 4: 412-423.
- Crisp, B., Barber, J. & Gilbertson, R. (1997) The etiquette of needle-sharing, *Contemporary Drug Problems*, 24, 2: 273-291.
- Crofts, N. (2000) Minimising harm from Hepatitis C virus needs better strategies, *British Medical Journal*, 321, 7265: 899.
- Crofts, N., Louis, R., Rosenthal, D. and Jolley, D. (1996) The first hit: circumstances surrounding initiation into injecting, *Addiction*, 91, 8: 1187-1196.
- Crofts, N., Louie, R. & Loff, B. (1997) The next plague: Stigmatisation and discrimination related to Hepatitis C virus infection in Australia, *Health and Human Rights*, 2, 2: 86-97.
- Crofts, N., Aitken, C.K. & Kaldor, J. (1999) The force of numbers: why hepatitis C is spreading amongst Australian injecting drug users while HIV is not, *Medical Journal of Australia*, 170, 5: 220-221.
- Crossan, E. & Amos, A. (1994) *Under a Cloud: Women, low income and smoking*. Edinburgh: Health Education Board for Scotland.
- Crowley, T.J. & Simpson, R. (1978) Methadone dose and human sexual behaviour, *International Journal of the Addictions*, 13, 2: 285-295.

- Cuijpers, P., Langendoen, Y. & Bijl, R. (1999) Psychiatric disorders in adult children of problem drinkers, first onset and comparison with other risk factors, *Addiction*, 94, 10: 1489-1498.
- Cumbria Strategic Partnership (2004) *Sustainable Cumbria: a strategy for growth and progress in Cumbria 2004-2024* accessed on 20 July 2006 at [www.cumbriastrategicpartnership.org.uk](http://www.cumbriastrategicpartnership.org.uk)
- Cumbria Strategic Partnership (2006) *Cumbria Agreement (Draft)* accessed on 20 July 2006 at [www.cumbriastrategicpartnership.org.uk](http://www.cumbriastrategicpartnership.org.uk)
- Cumbria Drug Action Team (2004) *Drugs Audit 2004 (Draft)*, Penrith: Cumbria DAT.
- Cumbria Drug Action Team (2005) personal communication, CDAT Staff Team.
- CUMBREN (2004) Cumbria Research Network, personal communication.
- Cusick, L., Martin, A & May, T. (2003) *Vulnerability and involvement in drug use and sex work .Research Study 268*. London: Home Office Research, Development and Statistics Directorate.
- Cuskey, W.R. (1982) Female addiction: A review of the literature, *Journal of Addiction and Health*, 3, 1: 3-33.
- Cutrona, C. & Suhr, J. (1990) The transition to parenthood, the need for social support. In S. Fisher & C.L. Cooper (eds.) *On the Move. The Psychology of Change and Transition*. Chichester: Wiley.
- Dahlgren, L. & Willander, A. (1989) Are special treatment facilities for female alcoholics needed? A controlled 2-year follow-up study from a specialised female unit (EWA) versus a mixed male/female treatment facility, *Alcoholism: Clinical and Experimental Research*, 13, 4: 499-504.
- Dale-Percora, A. (1998) Education, Education, Education, *Druglink*, 13, 3: 6.
- Daly, F. (1992) Drug Users on Bail: A Voluntary Agency's Experience. In N. Dorn, B. James & M. Lee (eds.) *Women, HIV, Drugs*. London: ISDD.
- Davies, A.G., Dominy, N.J., Peters, A.D. & Richardson, A.M. (1996) Gender differences in HIV risk behaviour of injecting drug users in Edinburgh, *AIDS Care*, 8, 5: 517-528.
- Davis, D.R. & Dinitto, D.M. (1996) Gender differences in social and psychological problems of substance abusers: a comparison to non-substance abusers, *Journal of Psychoactive Drugs*, 28, 2:135-145.
- Davis, S. (1994) Drug Treatment Decisions of Chemically Dependent Women, *The International Journal of the Addictions*, 29, 10: 1287-1304.
- Davis, T.M., Carpenter, K.M., Malte, C.A., Carney, M., Chambers, S. & Saxon, A.J. (2002) Women in addictions treatment: comparing VA and community samples, *Journal of Substance Abuse Treatment*, 23, 1: 41-48.

DAWN (1994) *When a crèche is not enough. A survey of drug and alcohol services for women*. London: Drug and Alcohol Women's Network.

Dear, L. (1995) Negotiated safety – what you don't know won't hurt you, or will it? *Drug and Alcohol Review*, 14, 3: 323-329.

Deehan, A., Taylor, C. & Strang, J. (1997) The general practitioner, the drug misuser, and the alcohol misuser: major differences in general practitioner activity, therapeutic commitment and 'shared care' proposals, *British Journal of General Practice*, 47, 424: 705-709.

De Leon, G. & Wexler, H.K. (1973) Heroin addiction in relation to sexual behaviour and sexual experience, *Journal of Abnormal Psychology*, 81, 1: 36-38.

Dennison, C. & Coleman, J. (2001) *Young People and Gender: A Review of Research*. London: Women's Unit, Cabinet Office.

Denton, B. & O'Malley, P. (1999) Gender, trust and business: women drug dealers in the illicit economy, *British Journal of Criminology*, 39, 4: 513-530.

Department for Education and Skills (DfES) (2006) *Participation in education, training and employment by 16 to 18 year olds in each local authority area in England: 2004-2005*, Report 465 accessible at [www.dfes.gov.uk](http://www.dfes.gov.uk)

Department of Environment Food and Rural Affairs (DEFRA) (2004) *Social and economic change and diversity in rural England*. London: DEFRA Publications

Department of Health (DH) (1997) *Statistical Bulletin: statistics from the Regional Drug Misuse databases for six months ending March 1996*. London: Department of Health.

Department of Health (DH) (1999a) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: Department of Health.

Department of Health (DH) (1999b) *Drug Misuse and dependence: guidelines on clinical management*. London: The Stationery Office.

Department of Health (DH) (1999c) *Health Survey for England: Cardiovascular disease*. London: The Stationery Office.

Department of Health (DH) (2000) *Statistical Bulletin: statistics from the Regional Drug Misuse databases for six months ending March 2000*. London: Department of Health.

Department of Health (DH) (2004a) *Hepatitis C: Action Plan for England*. London: Department of Health.

Department of Health (DH) (2004b) *Standards for Better Health*. London: Department of Health.

Department of Health (DH) (2004c) *Choosing Health: Making Healthy Choices Easier*. London: The Stationery Office.

Department of Health (DH) (2005a) *Creating a Patient-led NHS: Developing the NHS Improvement Plan*. London: Department of Health.

Department of Health (DH) (2005b) *Implementing the new community pharmacy contractual framework (draft)*. London: Department of Health.

Department of Health (DH) (2006) *Responding to domestic abuse: a resource manual for health professionals*. London: Department of Health.

Department for Education and Skills (2006)

Des Jarlais, D.C., Friedman, S.R. & Strug, D. (1986) AIDS and needle sharing within the IV drug use subculture. In D.A. Feldman & T.M. Johnson (eds.) *Social Dimensions of AIDS: method and theory*. New York: Praeger.

Des Jarlais, D.C., Choopanya, K., Vanichseni, S., Plangsrinagarm, K., Sonchai, W., Carballo, M., Friedman, P. & Friedman, S.R. (1994) AIDS risk reduction and reduced HIV seroconversion among injection drug users in Bangkok, *American Journal of Public Health*, 84, 3: 452-455.

Des Jarlais, D.C., Friedman, S.R., Friedman, P., Wenston, J., Sotheran, J.L., Choopanya, K., Vanichsen, S., Raktham, S., Goldberg, D., Frischer, M., Green, S., Lima, E.S., Bastos, E.I. & Telles, P.R. (1995) HIV/AIDS-related behavior change among injecting drug users in different national settings, *AIDS*, 9, 6: 611-617.

Des Jarlais, D., Marmor, M., Paone, D., Titus, S., Shi, Q., Perlis, T., Jose, B. & Friedman, S.R. (1996) HIV incidence among injecting drug users in New York City syringe-exchange programs, *The Lancet*, 348, 9033: 987-991.

Des Jarlais, D., Friedman, S., Perlis, T., Chapman, T.F., Sotheran, J.L., Paone, D., Montcrosso, E. & Neaigus, A. (1999) Risk behaviours and HIV infection among new drug injectors in the era of AIDS in New York City, *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 20, 1: 67-72.

Dickerson, J.W.T. & Stimson, G. (1995) *Health in the inner city: Drugs in the city*. London: Royal Society of Health.

Dobash, R. & Dobash, R. (1980) *Violence against Wives: A case against the patriarchy*. London: Open Books.

Dobash, R. & Dobash, R. (1998) *Rethinking Violence Against Women*. London: Sage.

Dolan, K., Shearer, J., Macdonald, M., Mattick, R., Hall, W., & Wodak, A. (2003) A randomised controlled trial of methadone maintenance treatment versus waiting list control in an Australian prison system, *Journal of Drug and Alcohol Dependence*, 72: 59-65.

Donmall, M., Millar, t., Jones, A. & Morey H. (2002) *Treating Drug Misuse Part 1: Client Contacts*. Manchester: Drug Misuse Research Unit, University of Manchester.

Donmall, M., Watson, A., Millar, T. & Dunn, G. (2005) Outcome of waiting lists (OWL) study, *Research Summary 5*, London: National Treatment Agency

Donoghoe, M. (1992) Sex, HIV and the injecting drug user, *British Journal of Addiction*, 87, 3: 405-416.

Donoghoe, M., Dorn, N., James, C., Jones, S., Ribbens, J. & South, N. (1987) *How families and communities respond to heroin*. In N. Dorn & N. South (eds.) *A Land fit for Heroin: Drug Policies, Prevention and Practice*. Basingstoke and London: Macmillan.

Donoghoe, M.C., Stinson, G.V. & Dolan, K.A. (1989) Sexual behaviour of injecting drug users and associated risks of HIV for non-injecting partners, *AIDS Care*, 1, 1: 51-58.

Donoghoe, M.C. & Wodak, A. (1998) Health and social consequences of injecting drug use. In G. Stimson, D. C. Des Jarlais, & A. Ball. (eds.) *Drug Injecting and HIV Infection*. London: Taylor & Francis.

Dore, M.M., Kauffmann, E., Nelson-Zupko, L. & Granfort, E. (1996) Psychosocial functioning and treatment needs of latency-aged children from drug-involved families, *Families in Society: The Journal of Contemporary Human Sciences*, 77, 10: 595-604.

Dorn, N., Ribbens, J. & South, N. (1987) *Coping with a nightmare: family feelings about long-term drug use*. London: ISDD.

Douglas, M. (1986) *Risk Acceptability according to the Social Sciences*. London: Routledge & Kegan Paul.

Doyal, L., Payne, S., & Cameron, A. (2003) Promoting Gender equality in Health. A report to The Equal Opportunities Commission. Accessed online at [www.eoc.org.uk](http://www.eoc.org.uk) on 26 April, 2005.

Druglink (2003) Rethink needed on girls who aren't so bad: Editorial, *Druglink*, 18, 6: 3.

Dunscombe, J. & Marsden, D. (1995) 'Workaholics and Whingeing Women': Theorising Intimacy and Emotion work – The last frontier of gender inequality? *Sociological Review*, 43, 1:150-169.

Dunn, C., Deroo, L. & Rivara, P. (2001) The use of brief interventions adapted from motivational interviewing across behavioural domains: a systematic review, *Addiction*, 96, 12: 1725-1742.

Dwyer, R., Richardson, D., Ross, M., Wodak, A., Miller, M.E. & Gold, J. (1994) A comparison of HIV risk between men and women who inject drugs, *AIDS Education and Prevention*, 6, 5: 379-389.

Edmonds, K., Sumnall, H., McVeigh, J. & Bellis, M. (2005) *Drug prevention for children of drug users, Factsheet 9*. National Collaborating Centre for Drug Prevention, Liverpool: Liverpool John Moores University.

Eicher, A., Crofts, N., Benjamin, S., Deutschmann, P. & Rodger, A. (2000) A Certain Fate: Spread of HIV Among Young Injecting Drug Users in Manipur, North-East India, *AIDS Care*, 12, 4: 497-504.

Richler, M. (1981) Power, dependency, love and the sexual division of labour, *Journal of Women's Studies Quarterly*, 4, 2: 201-219.

El-Bassel, N., Gilbert, L., Schilling, R. & Wada, T. (2000) Drug abuse and partner violence among women in methadone treatment, *Journal of Family Violence*, 15, 3: 209-228.

Eldred, C. & Washington, W. (1976) Interpersonal relationships in heroin use by men and women and their role in treatment outcomes, *International Journal of Addiction*, 11, 1: 117-130.

El-Guebaly, N. (1995) Alcohol and poly-substance abuse among women, *Journal of the Canadian Psychiatric Association*, 40, 2: 73-79.

EMCDDA (European Monitoring Centre on Drugs and Drug Addiction) (2005) *Differences in Patterns of drug use between women and men*. Accessed online on 12 May 2006 at [www.emcdda.eu.int](http://www.emcdda.eu.int)

Emler, N. (2001) *The costs and causes of low self-esteem*. York: Joseph Rowntree Foundation.

Epele, M (2001) Excess, scarcity and desire among drug using sex workers, *Body & Society*, 7, 2: 161-179.

Epele, M (2002a) Scars, harm and pain: about being injected among drug using Latina women, *Journal of Ethnicity in Substance Abuse*, 1, 1: 47-70.

Epele, M (2002b) Gender, violence and HIV: women's survival in the streets, *Culture, Medicine and Psychiatry*, 26, 1: 33-54.

Ettorre, E. (1989) Women, Substance Abuse and Self-help. In S. MacGregor (ed.) *Drugs and British Society: Responses to a Social Problem in the Eighties*, London: Routledge.

Ettorre, E. (1992) *Women and Substance Use*. London: Macmillan.

Ettorre, E. (1994) Substance use and Women's Health. In (eds.) S. Wilkinson and C. Kitzinger *Women and Health: Feminist Perspectives*. London: Taylor & Francis.

Ettorre, E. (2004) Revisioning women and drug use: Gender sensitivity, embodiment and reducing harm, *International Journal of Drug Policy*, 15, 5-6: 327-335.

Ettorre, E. & Riska, E. (1995) *Gendered Moods: Psychotropics and Society*. Routledge: London

Evans, J.L., Hahn, J.A., Page-Shafter, K. et al. (2003) Gender differences in sexual and injection risk behaviour among active young injection drug users in San Francisco, *Journal of Urban Health*, 80, 1: 137-146.

Farkas, M.I. (1976) The addicted couple, *Drug Forum*, 5, 1: 81-87.

Farrell, M., House, S. & Taylor, S. (1998) Substance misuse and psychiatric co-morbidity: an overview of the OPCS National Psychiatric Morbidity Survey, *Addictive Behaviours*, 23: 908-919.

Faugier, J. & Sargeant, S. (1997) Sampling Hard to Reach Populations, *Journal of Advanced Nursing*, 26, 4: 790-797.

Fennema, J.S., Van Ameijden, E.J. Van den Hoek, A. & Coutinho, R.A. (1997) Young and recent-onset drug users are at high risk for HIV, *Addiction*, 92, 11: 1457-1466.

Fergusson, D.M. & Lynskey, M.T. (1997) Physical punishment/maltreatment during childhood and adjustment in young adulthood, *Child Abuse and Neglect*, 21, 7: 617-630.

Fergusson, D.M. & Lynskey, M.T. (1998) Conduct problems in childhood and psychosocial outcome in adolescence: a prospective study, *Journal of Emotional and Behavioural Disorders*, 6: 1: 2-18.

Finch, J. (1984) "It's great to have someone to talk to": The ethics and politics of interviewing women. In (eds.) C. Bell & H. Roberts *Social Researching: Politics, Problems, Practice*. London: Routledge and Kegan Paul.

Finkelstein, N. (1996) Using the relational model as a context for treating pregnant and parenting chemically-dependent women. In (eds.) B. Underhill and D.G. Finnegan *Chemical dependency: Women at Risk*. New York: Haworth Press.

Fitzgerald, J. & Hamilton, M. (1996) The consequences of knowing: ethical and legal liabilities in illicit drug research, *Social Science and Medicine*, 43, 11: 1591-1600.

Finnegan, L. P. (1981) Maternal and Neonatal Effects of Drug Dependence in Pregnancy. In J.H. Lowinson & P. Ruiz (eds.) *Substance Abuse: Clinical Problems and Perspectives*. Baltimore: Williams & Wilkins.

Finnegan, L.P. (1988) Drug addiction and pregnancy: the newborn. In I.J. Chasnoff (ed) *Drugs, Alcohol, Pregnancy and Parenting*. Dordrecht: Kluwer Academic.

Finney, A. (2004) *Alcohol and intimate partner violence: key findings from the research. Findings No.215*. London: Home Office Research, Development and Statistics Directorate.

Fishman, P. (1990) Interaction: the work women do. In J. McCarl Nielsen (ed.) *Feminist Research Methods: Exemplary Reading in the Social Sciences*. London: Westview.

Flood-Page, C. & Taylor, J. (eds.) (2003) *Crime in England and Wales 2001/2002: Supplementary volume*. London: Home Office.

Florentine, R., Nakashima, J. & Anglin, M.D (1999a) Client engagement of drug treatment, *Journal of Substance Abuse Treatment*, 17, 3: 199-206.

Florentine, R. & Hillhouse, M.P. (1999b) Drug treatment effectiveness and client-counsellor empathy: exploring the effects of gender and ethnic congruency, *Journal of Drug Issues*, 29, 1: 59-74.

Forsyth, A. & Barnard, M. (1999) Contrasting levels of adolescent drug use between adjacent urban and rural communities in Scotland, *Addiction*, 94, 11: 1707-1718.

Foucault, M. (1979) *Discipline and Punish: The Birth of the Prison* (translated by A. Sheridan, Original work published in 1975). London: Penguin.

Fowlic, P.W. & McHaffie, H. (2004) ABC of pre-term birth: supporting parents in the neonatal unit, *British Medical Journal*, 329, 7478: 1336-1338.

Fraser, J. (1997) Methadone clinic culture: the everyday realities of female methadone clinics, *Qualitative Health Research*, 7, 1: 121-139.

Freund, M., Leonard, T.L. & Lee, N. (1989) Sexual behaviour of resident street prostitutes with their clients in Camden, New Jersey, *Journal of Sex Research*, 26: 460-478.

Friedman, S.R., Des Jarlais, D.C. & Sterk, C. *et al* (1990) AIDS and the social relations of intravenous drug users, *Millbank Quarterly*, 68 (Suppl.1): 85-110.

Friedman, S.R., Neaigus, A., Des Jarlais, D.C., Sothoran, J.L., Sufian, M., Stephenson, B. & Sterk, C. (1992) Social intervention against AIDS among injecting drug users, *British Journal of Addiction*, 87, 3: 393-404.

Friedman, J. & Alicea, M. (1995) Women and heroin: the path of resistance and its consequences, *Gender and Society*, 9, 4: 432-449.

Frischer, M. (1995) Mapping the nature and extent of drug use in a community: The Glasgow experience. In J.W.T. Dickerson & G. Stimson (eds.) *Health in the inner city: Drugs in the city*. London: Royal Society of Health.

Fry, C. & Dwyer, R. (2001) For love or money? An exploratory study of why injecting drug users participate in research, *Addiction*, 96, 9: 1319-1325.

Fullilove, M.T. & Fullilove, R.E. (1989) Intersecting epidemics: black teen crack use and sexually transmitted disease, *Journal of the American Women's Medical Association*, 44, 5: 146-7, 151-153.

Gabriel, M. (2006) Youth migration and social advancement: how young people manage emerging differences between themselves and their home town, *Journal of Youth Studies*, 9, 1: 33-46.

Garfein, R., Vlahov, D., Galia, N., DeHerty, M.C., Nelson, K.E. (1996) Viral infections in short-term injection drug users: The prevalence of hepatitis C, hepatitis B and human T-lymphocyte viruses, *American Journal of Public Health*, 86, 5: 655-661.

Gavey, N. (1992) Technologies and effects of heterosexual coercion, *Feminism and Psychology*, 2, 3: 325-351.

- Ghodse, H., Clancy, C., Oyefeso, A. et al (2003) The impact of methadone substitution therapy (MST) on illicit drug use and drug abuse-related quality of life, *Heroin Addiction and Related Clinical Problems*, 5, 1: 5-16.
- Gibson, D.R., Flynn, N.M. & Perales, D. (2001) Effectiveness of syringe exchange programmes in reducing HIV risk behavior and HIV sero-conversion among injecting drug users, *AIDS*, 15, 11: 1329-1341.
- Giddens, A. (1991) *Modernity and Self Identity: self and society in the late modern age*. Cambridge: Polity Press.
- Giddens, A. (1992) *The Transformation of Intimacy: sexuality, love and eroticism in modern societies*. Polity Press: Cambridge.
- Giggs, J., Bean, P., Whynes, D. & Wilkinson, C. (1989) Class A drug users: prevalence and characteristics in Greater Nottingham, *British Journal of Addiction*, 84, 12: 1473-1480.
- Gilbert L. (1997) Why women do and do not access street-based services, *Drug News*, 17: 30-34.
- Gilbert, L., El Bassel, N., Rajah, V., Foleno, A. & Frye, V. (2001) Linking drug-related activities with intimate partner violence: A focus group study of women in methadone treatment, *Violence and Victims*, 16, 5: 517-536.
- Gilchrist, E. (2003) *Domestic Violence Offenders: characteristics and offending-related needs, Findings 217*. London: Home Office.
- Gilvarry, E. (1998) Young drug users: Early intervention, *Drugs: Education, Prevention and Policy*, 5, 3: 281-292.
- Gilvarry, E. (2000) Substance abuse in young people, *Journal of Child Psychology and Psychiatry*, 41, 55-80.
- Glanz, A. & Taylor, C. (1986) Findings of a national survey of the role of general practitioners in the treatment of opiate use: extent of contact with opiate misusers, *British Medical Journal*, 293, 6546: 427-430.
- Glaser, B. & Strauss, A. (1967) *The Discovery of Grounded Theory*. Chicago: Aldine.
- Goffmann, E. (1959) The Moral Career of the Mental Patient. In E. Rubington & M.S. Weinberg (eds.) (2nd edition, 1973) *Deviance: The Interactionist Perspective*. New York: The Macmillan Company.
- Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, N.J.: Prentice Hall.
- Goldberg, D., Cameron, S. & McMenamin, J. (1998) Hepatitis C antibody prevalence among IDU in Glasgow has fallen but remains high, *Communicable Disease and Public Health*, 1, 2: 95-97.

- Goode, S.D. (2000) Researching a hard to access and vulnerable population: some considerations on researching drug and alcohol-using mothers. *Sociological Research online* 5, 1. [www.socresonline.org.uk](http://www.socresonline.org.uk) accessed on 28. 12. 2003.
- Gore-Felton, C., Vosvick, M., Bendel, T., Koopman, C., Das, B., Israelski, D., Herrera, M., Litzenberg, K. & Spiegel, D. (2003) Correlates of sexually transmitted disease infection among adults living with HIV, *International Journal of STD and AIDS*, 14, 8: 539-546.
- Gossop, M. (1998) *Living with Drugs*. (4<sup>th</sup> edition) Aldershot: Ashgate Publishing.
- Gossop, M. (2005) *Treatment outcomes: What we know and what we need to know*. Treatment Effectiveness series 2. London: National Treatment Agency.
- Gossop, M., Griffiths, P., Powis, B. & Strang, J. (1993) Severity of heroin dependence and HIV risk II: Sharing injecting equipment, *AIDS Care*, 5, 2: 159-168.
- Gossop, M., Griffiths, P. & Strang, J. (1994) Sex differences in patterns of drug-taking behaviour – a study at a London community drug team, *British Journal of Psychiatry*, 164: 101-104.
- Gossop, M., Marsden, J. & Stewart, D. (2000) Treatment outcomes of stimulant misusers: one year follow up results from the National Treatment Outcome Research Study (NTORS), *Addictive Behaviours*, 25, 4: 509-522.
- Gossop, M., Stewart, D., Treacy, S. & Marsden, J. (2002a) Factors associated with abstinence, lapse and relapse to heroin use after residential treatment: protective effect of coping responses, *Addiction*, 97: 1259- 1267.
- Gossop, M., Stewart, D., Treacy, S. & Marsden, J. (2002b) A prospective study of mortality among drug misusers over a four year period after seeking treatment, *Addiction*, 97, 1: 39-47.
- Goulden, C. & Sondhi, A. (2001) *At the margins: drug use by vulnerable young people in the 1998/1999 Youth Lifestyles Survey*, Home Office Research Series 228. London: Home Office.
- Graham, H. (1982) Coping: or how mothers are seen and not heard. In (eds.) S. Friedman & E. Sarah *On the Problem of Men*. London: Women's Press.
- Graham, H. (1983) Caring: A Labour of Love. In J. Finch & D. Groves (eds.) *Women, Work and Caring*. London: Routledge Kegan Paul.
- Graham, H. (1984) *Women, Health and the Family*. Brighton: Wheatsheaf.
- Graham, H. (1993) *When life's a drag: Women, Smoking and Disadvantage*. London: HMSO.
- Graham, K. & Gillis, K. (1999) The relationship between psychosocial well-being and alcohol and drug use following substance misuse treatment, *Substance Use & Misuse*, 34, 9: 1199-1222.

- Green, S., Mohsen, A., McKendrick, M., Dawes, Y., Prakasam, S., Walberg, R. & Schmid, M. (2001) Potential for Hepatitis C transmission among non-needle-syringe sharing Sheffield drug injectors through the sharing of drug preparation paraphernalia, *Communicable Disease and Public Health*, 4, 1: 38-41.
- Green A. & Owen, D. (2006) *The geography of poor skills and access to work*. York: Joseph Rowntree Foundation.
- Green, C.A., Polen, M.R., Dickinson, D.M. *et al.* (2002) Gender differences in predictions of initiation, retention and completion in an HMO-based substance abuse treatment program, *Journal of Substance Abuse Treatment*, 23, 4: 285-295.
- Green, C.A. & Pope, C.R. (1999) Gender, psychosocial factors and the use of medical services: a longitudinal analysis, *Social Science and Medicine*, 48, 10: 1363-1372.
- Greenfield, S.F., Manwani, S.G. & Nargiso, J.E. (2003) Epidemiology of substance use disorders in women, *Obstetrics and Gynecology Clinics of North America*, 30, 3: 413-446.
- Grella, C.E & Joshi, V. (1999) Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study, *American Journal of Drug and Alcohol Abuse*, 25, 3: 385-406.
- Griffin, M.L. & Mirin, S.M. (1989) A comparison of male and female cocaine abusers, *Archives of General Psychiatry*, 46, 2: 122-125.
- Griffin-Shelley, E. (1986) Sex roles in addiction: defense or deficit? *International Journal of Addiction*, 21, 12: 1307-1312.
- Griffiths, R. & Pearson, B. (1988) *Working with Drug Users*. Aldershot: Wildwood House.
- Gruer, L., Cameron, J., Elliott, L. (1993) Building a city-wide service for exchanging needles and syringes, *British Medical Journal*, 306, 6889: 1394-1397.
- Gurdin, J.B. & Patterson, C.B. (1987) The problem of sample frame in populations called deviant: the case of methadone maintained women and their infants, *Journal of Community Psychology*, 15: 459-469.
- Habib, S.E. & Adorjany, L.V. (2003) Hepatitis C and injecting drug use: The realities of stigmatisation and discrimination, *Health Education Journal*, 62, 3: 256-265.
- Hagan, H., Thiede, H., Weiss, N., Hopkins, S.G., Duchin, J.S. & Alexander, E.R. (2001) Sharing of drug preparation equipment as a risk factor for hepatitis C, *American Journal of Public Health*, 91, 1: 42-46.
- Hague G. & Malos, E. (1998) *Domestic Violence: Action for change*. (second edition) Trowbridge: The Cromwell Press.
- Hall, D. & Hall, I. (1996) *Practical Social Research*. London: Macmillan.

- Hammersley, R., Marsland, L. & Reid, M. (2003) *Substance use by young offenders: the impact of the normalisation of drug use in the early years of the 21<sup>st</sup> century*: Home Office Research Series 261. London: Home Office Research, Development and Statistics.
- Hanke, P.J. & Faupel, C.E. (1993) Women opiate users' perceptions of treatment services in New York City, *Journal of Substance Abuse Treatment*, 10, 6: 513-522.
- Harbin, F. & Murphy, M. (2000) *Substance misuse and child care: How to understand, assist and intervene when drugs affect parenting*. Lyme Regis: Russell House Publishing.
- Hartgers, C (1989) AIDS and Drugs, *AIDS Care*, 1, 2: 206-211.
- Hartnoll (1992) Research and the help-seeking process, *British Journal of Addiction*, 87, 3: 429-437.
- Hawkins, J.D., Cetalano, R.F. & Arthur, M. (2002) Promoting science-based prevention in communities, *Addictive Behaviours*, 27: 951-976.
- Hay, G., McKeganey, N., & Hutchinson, S. (2001) *Estimating the national and local prevalence of problem drug use in Scotland*. Centre for Drug Misuse Research, University of Glasgow.
- Health Advisory Service (1996) *Children and Young People's Substance Misuse Services*, London: HMSO.
- Health Protection Agency, SCIEH, National Public Health Service for Wales, CDSC, Northern Ireland, CRDHB, and the UASSB (2004) *Shooting up: Infections among injecting drug users in the United Kingdom 2003*, London: Health Protection Agency.
- Heimer, R., Khoshnood, K., Jariwala-Freeman, B., Duncan, B. & Harima, Y. (1996) Hepatitis in used syringes: the limits of sensitivity of techniques to detect Hepatitis B virus DNA, Hepatitis C virus RNA and antibodies to HBV core and HCV antigens, *Journal of Infectious Diseases*, 173: 997-1000.
- Henderson, S. (1993) Luv'dup and de-elited: responses to drug use in the second decade. In P. Aggleton, P. Davies & G. Hart. (eds.) *AIDS: Facing the Second Decade*. London: Falmer Press.
- Henderson, S. (1997) *Ecstasy: Case unsolved*. London: Pandora.
- Henderson, S. (1998) *Drugs prevention in rural areas: an evaluation report: Final report to the Home Office Drugs Prevention Initiative, Paper 17*, London: Home Office.
- Henderson, S. (1999) Drugs and Culture: The question of gender. In (ed.) N. South *Drugs, Cultures, Controls and Everyday Life*. London: Sage.
- Henwood, K. & Pidgeon, N. (1995) Remaking the Link: Qualitative Research and Feminist Standpoint Theory, *Feminism and Psychology*, 5, 1: 7-30.

- Hepburn, M. (1993) Drug misuse in pregnancy, *Current Obstetrics and Gynaecology* 3, 1: 54-58.
- Hepburn, M. (1994) Preventing HIV Infection in Female Drug Users, *Maternal and Child Health*, 19, 3: 91-95.
- Hepburn, M. (1996) Drug use in Pregnancy: sex, drugs and fact 'n fiction, *Druglink*, 11, 4: 12-14.
- Hepburn, M. (2000) *Gender issues: women's perspectives in substance misuse*. Paper at the Substance Misuse and Child Protection conference. London, June 2000.
- Hepburn, M. (2002) Drug use and women's reproductive health. In T. Peterson & A. McBride (eds.) *Working with substance misusers: A guide to theory and practice*. London: Routledge.
- Hepburn, M. (2004) Drug and/or alcohol related deaths. In *Why Mothers Die 2000-2002*, London: Royal College of Obstetricians and Gynaecologists.
- Hester, M., Harwin, N. & Pearson, C. (2000) *Making an impact - children and domestic violence*. London: Jessica Kingsley.
- Hickman, M., Higgins, V., Hope, V.D., Bellis, M.A., Tilling, K. *et al* (2004) Injecting drug use in Brighton, Liverpool and London: Best estimates of prevalence and coverage of public health indicators, *Journal of Epidemiology and Community Health*, 58: 766-771.
- Hien, D. & Scheier, J. (1996) Trauma and short-term outcome for women in detoxification, *Journal of Substance Abuse Treatment*, 13, 3: 227-231.
- Hill, A. & Williams, J. (1998) Psychological health in a non-clinic sample of obese women, *International Journal of Obesity*, 22, 6: 578-583.
- Hodgins, D.C., El-Guebaly, N. & Addington, J. (1997) Treatment of Substance Abusers: single or mixed gender programs, *Addiction*. 92, 7: 805-812.
- Hoff, L.A. (1990) *Battered Women as Survivors*. London: Routledge.
- Hoffmann, J.P. & Hsu, S.S. (1998) Parental substance use disorder, mediating variables and adolescent drug use: a non-recursive model, *Addiction*, 93, 9: 1351-1364.
- Hoffmann, J.P. & Cerbone, F.G. (2002) Parental substance use disorder and the risk of adolescent drug abuse: an event history analysis, *Drug and Alcohol Dependence*, 66: 255-264.
- Hogan, D.M. (1998) Annotation: The Psychological Development and Welfare of Children of Opiate and Cocaine Users: Review and Research Needs, *Journal of Child Psychology and Psychiatry*, 39, 5: 609-619.
- Hogg, C., Chadwick, T. & Dale-Perera, A. (1997) *Drug Using Parents: Policy Guidelines for Inter-agency Working (England and Wales) (LGDF/SCODA)*, London: LGA Publications.

Holdaway, C. & Davis, P. (1996) *Reaching out: a study of hidden populations of drug users. Final report of a needs assessment project*. Bognor Regis: The Summit Community Drug Problem Team.

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. & Thomson, R. (1990a) *Don't Die of Ignorance. I Nearly Died of Embarrassment: Condoms in Context*. London: Tufnell Press.

Holland, J., Ramazanoglu, C. & Scott, S. (1990b) AIDS: From panic stations to power relations: sociological perspectives and problems, *Sociology*, 25, 3: 499-518.

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. & Thomson, R. (1992a) Risk, power and the possibility of pressure: young women and safer sex, *AIDS Care*, 4, 3: 273-283.

Holland, J., Ramazanoglu, C., Sharpe, S. & Thomson, R. (1992b) Pleasure, pressure and power: some contradictions of gendered sexuality, *Sociological Review*, 40, 4: 645-674.

Holland, J., Ramazanoglu, C., Scott, S. & Thompson, R. (1992c) Pressure, resistance, empowerment: Young women and the negotiation of safer sex. In P. Aggleton, G. Hart & P. Davies (eds.) *AIDS: Rights, Risk and Reason*. London: Falmer Press.

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. & Thomson, R. (1992d) Pressured pleasure: Young women and the negotiation of sexual boundaries, London: Tufnell Press.

Holland, J., Ramazanoglu, C., Sharpe, S. & Thompson, R. (1998) *The Male in the Head: Young people, heterosexuality and power*. London: Tufnell Press.

Hollway, W. (1989) *Subjectivity and Method in Psychology: Gender, Meaning and Science*. London: Sage.

Holsten, F. (1985) The female drug abuser: has she a shorter way out? *Journal of Drug Issues*, 15, 3: 383-392.

Horgan, A., Cassidy, C.E. & Corrigan, A. (1998) Childhood sexual abuse histories in women with drug and alcohol misuse disorders, *Irish Journal of Psychological Medicine*, 15, 3: 91-95.

House of Commons Home Affairs Select Committee (2002) *Review of Drug Policy*. London: The Stationery Office.

Howard League of Penal Reform (2006) *Once upon a time in the west: social deprivation and youth crime*. London: Howard League of Penal Reform.

Hser, Y., Anglin, M.D., & McGlothlin, W.H. (1987) Sex differences in addict careers: 1 Initiation of use, *American Journal of Drug and Alcohol Abuse*, 13, 1: 33-57.

Hser, Y., Anglin, D. & Powers, K. (1993) A 24 year follow-up of Californian narcotics addicts, *Archives of General Psychiatry*, 50, 7: 577-584.

Hser, Y., Anglin, M.D., Grella, C. Longshore, D. & Prendergast, M.L. (1997) Drug treatment careers: a conceptual framework and existing research findings, *Journal of Substance Abuse Treatment*, 14, 6: 543-558.

Hser, Y., Hoffman, V., Grella, C. & Anglin, D. (2001) A 33-year follow-up of narcotics addicts, *Archives of General Psychiatry*, 58: 503-508.

Hsu, L.N. & Du Guerny, J. (1995) Towards a gender-sensitive approach to drug demand reduction: a process within the United Nations system, *Bulletin on Narcotics; Focal Point on Women*, 47, 1-2: 1-14.

Huizink, A.C., Ferdinand, R.F, Van den Erde, J. & Verhulst, F.C. (2006) Symptoms of anxiety and depression in childhood and use of MDMA: prospective, population-based study, *British Medical Journal*, 332, 7545: 825-828.

Hunt, N., Stillwell, G., Taylor, C. & Griffiths, P. (1998) Evaluation of a brief intervention to prevent initiation into injecting, *Drugs: Education, Prevention and Policy*, 5, 2: 185-194.

Hunt, N., Joe-Laidler, K. & Evans, K. (2002) The meaning and gendered culture of getting high: gang girls and drug use issues, *Contemporary Drug Problems*, 29, 2: 375-416.

Hunt, N., Ashton, M., Lenton, S, et al (2003) *A review of the evidence-base for harm reduction approaches to drug use*, accessed at [www.forward-thinking-on-drugs.org/review2-print.html](http://www.forward-thinking-on-drugs.org/review2-print.html) on 25 June 2005.

Hunt, N., Trace, M. & Bewley-Taylor, D. (2005) *Reducing Drug Related Harms to Health: An Overview of the Global Evidence*, The Beckley Foundation Drug Programme, accessed on 28 December 2005 at [www.beckleyfoundation.org/pdf/report\\_drugrelatedharms.pdf](http://www.beckleyfoundation.org/pdf/report_drugrelatedharms.pdf)

Hunter, G.M., Stimson, G.V., Judd, A., Jones, S. & Hickman, M. (2000) Measuring injecting risk behaviour in the second decade of harm reduction: a survey of injecting drug users in England, *Addiction*, 95, 9: 1351-1361.

Hurley, S.F., Jolley, D.J. & Kaldor, J.M. (1997) Effectiveness of needle-exchange programmes for prevention of HIV infection, *The Lancet*, 349, 9068: 1797-1800.

Hyde, J., Polyzoides, C., Montgomery, S.B. & Iverson, E. (2000) *Searching for Solace in a Vein: Life Histories of Young Injectors on the Street*. Paper presented at the American Public Health Association Meetings, Boston, MA, 2000.

Inciardi, J.A. & Pottieger, A.E. (1998) Drug use and street crime in Miami: An (almost) twenty year retrospective, *Substance Use & Misuse*, 33, 9: 1839-1870.

Itzin, C. (2006) *Tackling the Health and Mental health Effects of Domestic and Sexual Violence and Abuse*. London: Department of Health.

- Jackson, S. (1995) Women and Heterosexual Love: Complicity, resistance and change. In Pearce, L. and Stacey, J. (eds.) *Romance Revisited*. New York: New York University Press.
- Jacobs, J. & Tulloch, J. (1997) *Domestic violence and Substance Misuse: A survey of research and local practice*. Brighton: Brighton Safer Cities.
- Jacobs, J. (1998) *The links between substance misuse and domestic violence: current knowledge and debates*. London: Alcohol Concern.
- Jaffe, P., Wolfe, D. & Wilson, S. (1990) *Children of Battered Women*. Newbury Park: Sage.
- Jager, J., Limburg, W., Knetzchmer, M., Postma, M. & Wiessing, L. (2004) *Hepatitis C and injecting drug use: impacts, costs and policy options*. Luxembourg: Office of Official Publications of the European Communities.
- Jamieson, L. (1998) *Intimacy: Personal Relationships in modern societies*. Cambridge: Polity Press.
- Jamieson, L. (2000) Migration, place and class: youth in a rural area, *The Sociological Review*, 48, 2: 203-223.
- Jarvis, M.A., Wu-Pong, S., Kniseley, J.S. & Schnoll, S.H. (2000) Alterations in methadone metabolism during late pregnancy, *Journal of Addictive Diseases*, 18, 4: 51-61.
- Johns, A. (1988) Inhaling heroin during pregnancy, *British Medical Journal*, 296, 6633: 1399-1400.
- Johnson, B.D., Williams, T., Dei, K.A., & Sanabria, H. (1990) *Drug abuse in the inner-city: Impact on hard drug users and the community*. In M. Tonry & J.Q. Wilson (eds.) *Drugs and Crime*. Chicago: Chicago University Press.
- Johnston, L., MacDonald, R., Mason, P., Ridley, L. & Webster, C. (2000) *Snakes and Ladders: Young people, Transitions and Social Exclusion*. York: Joseph Rowntree Foundation.
- Jones, C., Armstrong, M., King, M. & Price, D. (2004) How pharmacy can help public health, *The Pharmaceutical Journal*, 272: 672-674.
- Jones, L., Hughes, M. & Unterstaller, U. (2001) Post-traumatic Stress Disorder in victims of domestic violence: a review of research, *Trauma, Violence and Abuse*, 2, 2: 99-119.
- Jones, S.S., Power, R. & Dale, A. (1994) The patients' charter: drug users' views on the 'ideal' methadone programme, *Addiction Research*, 1, 4: 323-334.
- Judd, A., Hickman, M., Jones, S., McDonald, T., Parry, J.V., Stimson, G.V. & Hall, A.J. (2004) Incidence of hepatitis C virus among new injecting drug users in London: prospective cohort study, *British Medical Journal*, 330, 7481: 24-25.
- Kandel, D. (1974) Inter- and intra-generational influences on adolescent marijuana use, *Journal of Social Issues*, 30, 2: 107-135-136.

- Kandel, D. (1990) Parenting styles: drug use and children's adjustment in families of young adults, *Journal of Marriage and the Family*, 52, 1: 183-196.
- Kane, S. (1991) HIV, Heroin and heterosexual relations, *Social Science and Medicine*, 32, 9: 1037-1050.
- Kantor, G.A. & Strauss, M.A. (1989) Substance misuse as a precipitant of wife abuse victimisation, *American Journal of Drug and Alcohol Abuse*, 15, 2: 173-189.
- Kearney, M.H., Murphy, S. & Rosenbaum, M. (1994) Mothering on crack cocaine: a grounded theory analysis, *Social Science and Medicine*, 38, 2: 351-361.
- Keen, J. & Alison, L. (2001) Drug misusing parents: key points for health professionals, *Archive of Diseases in Childhood*, 85: 296-299.
- Kelly, L., Burton, S. & Regan, L. (1994) Researching women's lives or studying women's oppression? Reflections on what constitutes feminist research. In M. Maynard & J. Purvis (eds.) *Researching Women's Lives from a Feminist Perspective*. London: Taylor Francis.
- Kendler, K.S., Bulik, C.M., Silberg, J., Hettema, J.M., Myers, J. & Prescott, C.A. (2000) Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and co-twin control analysis, *Archives of General Psychiatry*, 57, 10: 953-959.
- Kettinger, L.A., Nair, P. & Schuler, M.E. (2000) Exposure to environmental risk factors and parenting attitudes among substance-abusing women, *American Journal of Drug and Alcohol Abuse*, 26, 1: 1-11.
- Kirkwood, C. (1993) *Leaving abusive partners: from the scars of survival to the wisdom for change*. London: Sage Publications.
- Khundakar, A., Marr, A., McVeigh, J. & Bellis, M. (2006) *Drug Treatment in the North West of England 2005/2006*. Liverpool: Centre for Public Health, Liverpool John Moores University.
- Kitzinger, J. & Barbour, R. (1999) The challenge and promise of focus groups. In J. Kitzinger and R. Barbour (eds.) *Developing Focus Group research, Politics, Theory and Practice*. London: Sage.
- Kitzinger, S. (1978) *Women as Mothers*. Oxford: Martin Robertson.
- Klee, H. (1992) Knowledge of drug-related health problems among injecting drug users: Implications for the transmission of HIV infection, *Psychology and Health*, 6, 1-2: 53-60.
- Klee, H. (1993) HIV Risks for women drug injectors: heroin and amphetamine users compared, *Addiction*, 88, 8: 1055-1062.
- Klee, H. (1996) Women drug users and their partners. In L. Sherr, C. Hankins & L. Bennett (eds.) *AIDS as a Gender Issue: Psychosocial perspectives*. London: Taylor & Francis.

- Klee, H. (1997) Amphetamine injecting women and their primary partners: an analysis of risk behaviour. In L. Sherr, C. Hankins & L. Bennett (eds) *The Impact of AIDS: Psychological and Social Aspects of HIV Infection*. Abingdon, Oxon: Harwood Academic Publishers.
- Klee, H. (1998) Drug-using parents: analysing the stereotypes, *International Journal of Drug Policy*, 9, 6: 437-488.
- Klee, H. (2002) Informal support: partners and mums. In H. Klee., M. Jackson & S. Lewis (eds.) *Drug Misuse and Motherhood*. London & New York: Routledge.
- Klee, H., Faugier, J., Hayes, C., Boulton, T. & Morris, J. (1990) Factors associated with risk behaviour among IV drug users, *AIDS Care*, 2: 133-145.
- Klee, H., Faugier, J., Hayes, C. & Morris, J. (1991) The sharing of injecting equipment among drug users attending prescribing clinics and those using needle exchanges, *British Journal of Addiction*, 86, 2: 217-223.
- Klee, H., Morris, J. & Faragher, B. (1992) *Amphetamine misuse: implications for HIV transmission*, Final Report, London: Economic and Social Research Council.
- Klee, H., Morris, J., Ruben, S. & Prinjha, N. (1993) *Polydrug misuse: health risks and implications for HIV transmission. Final Report to the UK Department of Health*. Manchester: Manchester Metropolitan University, SRHSA.
- Klee, H. & Morris, J. (1995) The role of needle exchanges in modifying sharing behaviour: cross-study comparisons 1989-1993, *Addiction*, 90, 12: 1635-1645.
- Klee, H. & Jackson, M. (1998) *Illicit drug use, pregnancy and early motherhood*. Manchester: Manchester Metropolitan University, SRHSA.
- Klee, H., Jackson, M. & Lewis, S. (2002) *Drug Misuse and Motherhood*. London: Routledge.
- Kline, A. (1996) Pathways into drug user treatment: the influence of gender and racial/ethnic identity, *Substance Use and Misuse*, 31, 3: 323-342.
- Koester, S. (1994) Copping, running and paraphernalia laws: contextual variables and needle risk behaviour among injection drug users in Denver, *Human Organisation*, 53, 3: 287-295.
- Kosten, T.R., Rounsaville, B.J. & Kleber, H.D. (1985) Parental alcoholism in opioid addicts, *Journal of Nervous and Mental Diseases*, 173, 8: 461-469.
- Kral, A., Bluthenthal, R., Erringer, E., Lorvick, J. & Edlin, B. (1999) Risk factors among IDUs who give injections to or receive injections from other drug users, *Addiction*, 94, 5: 675-683.
- Kroll, B. & Taylor, A. (2003) *Parental substance misuse and child welfare*. London: Jessica Kingsley.
- Kuyper, L.M., Wood, E., Montaner, J.S., Yip, B., O'Connell, J.M. & Hogg, R.S. (2004) Gender Differences in HIV-1 RNA Rebound Attributed to Incomplete

Antiretroviral Adherence Among HIV-Infected Patients in a Population-Based Cohort, *Journal of Acquired Immune Deficiency Syndromes*, 37, 4: 1470-1476.

Larkin, C.A., Mandell, W., Knowlton, A.R., D'Herty, M.C., Vlahov, D., *et al.* (1998) Gender differences in injection-related behaviours among injection drug users in Baltimore, Maryland, *AIDS Education and Prevention*, 10, 3: 257-263.

Lawless, S., Kippax, S. & Crawford, J. (1996) Dirty, diseased and undeserving: the positioning of HIV positive women, *Social Science and Medicine* 43, 9: 1371-1377.

Laybourn, A, Brown, J., & Hill, M. (1996) *Hurting on the Inside: Children's experiences of parental alcohol misuse*. Aldershot: Avebury.

Lee, R.M. (1993) *Doing research on sensitive topics*. London: Sage.

Lemert, E.M. (1951) *Social Pathology: A Systematic Approach to the Theory of Sociopathic Behaviour*. New York and London: McGraw-Hill.

Lewis, S., Klee, H. & Jackson, M. (1995) Illicit drug users' experiences of pregnancy: an exploratory study, *Journal of Reproductive and Infant Psychology* 13, 3-4: 219-227.

Lex, B.W. (1991) *Gender differences and substance abuse*. In N.K Mello (ed.) *Advances in Substance Abuse Behavioural and Biological Research*. London: Jessica Kingsley.

Lex, B.W. (1993) Women and illicit drugs: marijuana, heroin and cocaine. In E. S.L. Gombert & T.D. Nirenberg (eds.) *Women and Substance Abuse*. Norwood, N.J.: Ablex Publishing.

Liebschutz, J.M., Mulvey, K.P. & Samet, J.H. (1997) Victimization among substance-abusing women, *Archives of Internal Medicine*, 157, 10: 1093-1097.

Lilly, R. & Rhodes, T. (1999) *Risk Factors Associated with Problem and Non-Problematic Drug Use*, Lisbon: European Monitoring Centre on Drugs and Drugs

Lindesmith, A, Strauss, A. & Denzin, N. (1977) *Social Psychology*, (2<sup>nd</sup> edition.) New York: Holt, Rinehart & Winston.

Lindo, M. (1987) Drug addiction: Its effects on mother and baby, *Midwifery*, 3, 2: 82-91.

Liu, X. & Kaplan, H.B. (1996) Gender-related differences in circumstances surrounding initiation and escalation of alcohol and other substance use/abuse, *Deviant Behaviour: An Interdisciplinary Journal*, 17: 71-106.

Lloyd, C. (1998) Risk factors for problem drug use: Identifying vulnerable groups, *Drugs: Education, Prevention and Policy*, 5, 3: 217-232.

Lofland, J. & Lofland, L.H. (1984) *Analysing Social Settings: A Guide to Qualitative Observation and Analysis*. Belmont, California: Wadsworth.

Lofty, C. (2003) Upping the ante: getting the dose right for pregnant drug users, *Druglink*, 18, 1:14-15.

Luchansky, B., He, L., Krupski, A. & Stark, K.D. (2000) Predicting readmission to substance abuse treatment using state information systems. The impact of client and treatment characteristics, *Journal of Substance Abuse*, 12, 3: 255-270.

Lupton, D. (1993) Risk as moral danger: the social and political functions of risk discourse in public health, *International Journal of Health Services*, 23, 3: 425-435.

Lupton, D. (1999) *Risk*. London: Routledge.

Lurie, P. & Drucker, E. (1997) An opportunity lost: HIV infections associated with lack of a national needle-exchange program in the USA, *The Lancet*, 349: 604-608.

Luthar, S., Merikangas, K., & Rounsaville, B. (1993) Parental psychopathology and disorders in offspring: a study of relatives of drug users, *The Journal of Nervous and Mental and Disease*, 181, 6: 351-357.

Lynskey, M., Fergusson, D. & Horwood, L. (1998) The origins of the correlations between tobacco, alcohol and cannabis use during adolescence, *Journal of Child Psychology and Psychiatry*, 39: 995-1007.

McArdle, P., Wiegersma, A., Gilvarry, E., Kalte, B., McCarthy, S., Fitzgerald, M., Brinkley, A., Blom, M., Stoeckel, I., Pierolini, A., Michels, I., Johnson, R. & Quensel, S. (2002) European adolescent substance use: the roles of family structure, function and gender, *Addiction*, 97, 3: 329-336.

McBride, A. Pates, R. Arnold, K. Ball, N (2001) Needle fixation, the drug users perspective: a qualitative study, *Addiction*, 96, 7: 1049-1058.

McCance-Katz, E.F., Carroll, K.M., & Rounsaville, B.J. (1999) Gender differences in treatment seeking cocaine abusers: Implications for treatment and prognosis, *American Journal on Addiction*, 8, 4: 300-311.

MacDonald, M., Crofts, N. & Kaldor, J. (1996) Transmission of hepatitis C virus: rates, routes and co-factors, *Epidemiologic Reviews*, 18, 2: 137-148.

MacDonald, M.A., Wodak, A.D., Dolan, K.A., Van Beek, I., Cunningham, P.H. & Kaldor, J.M. (2000) Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia (1995-1997), *Medical Journal of Australia*, 172: 57-61.

McIntosh, J. & McKeganey, N. (2000) Addicts' narratives of recovery from drug use: constructing a non-addict identity, *Social Science and Medicine*, 50, 10: 1501-1510.

McIntosh, J. & McKeganey, N. (2001) Identity and recovery from dependent drug use: The addict's perspective, *Drugs: Education, Prevention and Policy* 8, 1: 47-59.

- McIntosh, J. & McKeganey, N. (2002) *Beating the Dragon: the recovery from dependent drug use*. Harlow, Essex: Prentice Hall.
- McIntosh, J., MacDonald, F. & McKeganey, N. (2005) Pre-teenage children's strategies for avoiding situations in which they may be exposed to drugs, *Drugs: Education, Prevention and Policy*, 16: 37-45.
- McIntyre, A. (1998) Burden of illness: A review of obesity – are the true costs realised? *Journal of the Royal Society for the Promotion of Health*, 118, 2: 76-84.
- McKeganey, N. (1995) Quantitative and qualitative research in addictions: An unhelpful divide, *Addiction*, 90, 6: 749-751.
- McKeganey, N. (2001) To pay or not to pay: respondents' motivation for participating in research, *Addiction*, 96, 9: 1237-1238.
- McKeganey, N. & Barnard, M. (1992) *AIDS, Drugs and Sexual Risk: Lives in the Balance*. Buckingham: Open University Press.
- McKeganey, N. & Barnard, M. (1996) *Sex work on the streets: prostitutes and their clients*. Buckingham: Open University Press.
- McKeganey, N., Abel, M., Taylor, A., Frischer, M., Goldberg, D., & Green, S. (1995) The preparedness to share injecting equipment: an analysis using vignettes, *Addiction*, 90, 9: 1253-1260.
- McKeganey, N. & Norrie, J. (1999) Pre-teen Drug Users in Scotland, *Addiction Research*, 7, 6: 493-507.
- McKeganey, N., Barnard, M. & McIntosh, J. (2002) Paying the price for their parents' addiction: meeting the needs of the children of drug using parents, *Drugs: Education, Prevention and Policy*, 9, 3: 233-246.
- McKeganey, N. & Bloor, M. (2004) *What happens to drug users in Scotland sixteen months after they contact drug treatment services? Results from the Drug Outcome Research in Scotland Study*. Centre for Drug Misuse Research: University of Glasgow.
- McKeganey, N., Neale, J. & Robertson, M. (2005) Physical and sexual abuse among drug users contacting drug treatment services in Scotland, *Drugs: Education, Prevention and Policy*, 12, 3: 223-232.
- McNeill, A. (1998) *Alcohol Problems in the Family*, Report to the European Union. Cambridge: Eurocare.
- MacRae, R. & Aalto, E. (2000) Gendered power dynamics and HIV risk in drug using sexual relationships, *AIDS Care*, 12, 4: 505-515.
- Macrory, F. (1997) *Drug use, pregnancy and the care of the newborn: a guide for professionals*. Manchester: St Mary's Hospital for Women and Manchester Drug Service.
- Macrory, F. (2002) The drug liaison midwife. In H. Klee, M. Jackson & S. Lewis. (eds.) *Drug Misuse and Motherhood*. London & New York: Routledge.

Maher, L. (1995) *In the name of love: Women and initiation to illicit drugs*. In R. Dobash, R. Dobash & L. Noaks (eds.) *Gender and Crime*. Cardiff: University of Wales Press.

Maher, L. (1997) *Sexed work: gender, race and resistance in a Brooklyn drugs market*. Oxford: Clarendon Press.

Maher, L. (1998) *Running the Risks: heroin, health and harm*. Sydney: Australian National Drug and Alcohol Research Centre.

Malinowski, B. (1922) *Argonauts of the Western Pacific: an account of native enterprise and adventure in the archipelagoes of Melanesian New Guinea*. New York: Dutton.

Malloch, M. (1999) Drug use, prison and the social construction of femininity, *Women's Studies International Forum*, 22, 3: 349-358.

Mansfield, P. & Collard, J. (1988) *The beginning of the rest of your life? A portrait of newly-wed marriage*. Basingstoke: Macmillan.

Marcenko, M.O., Kemp, S. & Larson, N.C. (2000) Childhood experiences of abuse, later substance abuse and parenting outcomes among low-income mothers, *American Journal of Orthopsychiatry*, 70, 3: 316-326.

Markowitz, R. (1993) *Dynamics and treatment issues with children of drug and alcohol abusers*. In Shulasmith Lala & Ashenberg Strausner (eds.) *Clinical work with substance abusing clients*. New York: The Guilford Press.

Marsden, J.C., Gossop, M., Stewart, D., Rolfe, A. & Farrel, M. (2000) Psychiatric symptoms among clients seeking treatment for drug dependence: Intake data from the NTORS study, *British Journal of Psychiatry*, 176: 285-289.

Marsh, K. & Simpson, D. (1986) Sex differences in opioid addiction careers, *American Journal of Drug and Alcohol Abuse*, 12, 4: 309-329.

Marsh, J.C., D'Aunno, T.A. & Smith, B.D. (2000) Increasing access and providing social services to improve drug abuse treatment for women with children, *Addiction*, 95, 8: 1237-1247.

Marshall, A. (1993) Commentary: Ways of Coping with Excessive Drug Use in the Family, *Journal of Community and Applied Social Psychology*, 3, 1: 67-69.

Maslow, A. (1987) *Motivation and Personality* (3<sup>rd</sup> edition). New York: Harper and Row.

Matthews, L. (1990) Book Review: H. Shapiro, *Drugs, Pregnancy and childcare: A guide for professionals*, *International Journal of Drug Policy*, 2, 3: 30-31.

Mauss, M. (1954) *The Gift: Forms and Functions of Exchange in Archaic Societies*, New York: Cohen & West.

Maxwell, C. & Boyle, M. (1995) Risky heterosexual practices amongst women over 30: Gender, power and long-term relationships, *AIDS Care*, 7, 3: 277-293.

Maynard, M. & Purvis, J. (1994) *Researching women's lives from a feminist perspective*. London: Taylor and Francis.

Measham, F. (2002) Doing gender- 'doing drugs': Conceptualising the gendering of drugs cultures, *Contemporary Drug Problems*, 29, 2: 335-373.

Measham, F., Parker, H. & Aldridge, J. (1998) *Starting, Switching, Slowing and Stopping, Report of the Drugs Prevention Initiative Integrated Programme*. London: Home Office.

Meek, R. (2006) Social deprivation and youth crime: young men in prison and their experience of the rural idyll, *Crime Prevention and Community safety*, 8, 2: 90-103.

Meier, P.S., Donmall, M., & McElduff, P. (2004) Characteristics of drug users who do or do not have care of their children, *Addiction*, 99: 955-961.

Melrose, M. & Brodie, I. (2000) *Vulnerable young people and their vulnerability to drug misuse*. In K. Evans & S. Alade (eds.) *Vulnerable young people and drugs: opportunities to tackle inequalities, Research to Practice 2*. London: Drugscope.

Mentor UK (2004) *Mentor UK Rural Youth Project: involving rural young people in evaluation. Final report*. Accessed on 24 April 2006 at [www.dh.gov.uk](http://www.dh.gov.uk)

Metsch, L.R., McCoy, C.B., McCoy, H.V., Shultz, J., Inciardi, J., Wolfe, H. & Correa, R. (1998) Social Influences: Living Arrangements of Drug Using Women at Risk for HIV Infection. In S.J. Stevens, S. Tortu & S.L. Coyle (eds.) *Women, Drug Use and HIV Infection*, New York: The Haworth Press.

Midgely, J., Ashton, N., Castles, H., McNamara, J., Tocque, K. & Bellis, M. (2003) *Health Environment and Deprivation in the North West of England*. Liverpool: Centre for Public Health, John Moores University.

Mientjes, G.H.C., Miedema, F., van Ameijden, E., van den Hoek, A., Schellekens, P., Roos, M. & Coutinho, R.A. (1991) Frequent injecting impairs lymphocyte reactivity in HIV positive and HIV negative drug users, *AIDS*, 5, 1: 35-41.

Millar, T., Craine, N., Carnwath, T. & Donmall, M. (2001) The dynamics of heroin use: implications for intervention, *Journal of Epidemiology and Community Health*, 55: 930-933.

Miller, B.A., Downs, W. R. & Gondoli, D.M. (1989) Spousal violence among alcoholic women as compared to a random household sample of women, *Journal of Studies in Alcohol*, 50, 6: 533-540.

Miller, B.A., Downs, W.R. & Testa, M. (1993) Inter-relationships between victimisation experiences and women's alcohol/drug use, *Journal of Studies on Alcohol*, supplement 11: 109-117.

Miller, J. (1996) Addressing the issues of contraception in substance misuse services: Is it a concern? *Psychiatric Care*, 3, Supplement 1: 24-27.

- Miller, M. & Neaigus, A. (2001) Networks, resources and risk among women who inject drugs, *Social Science and Medicine*, 52, 6: 967-978.
- Miller, P. (1997) Family structure, personality, drinking, smoking and illicit drug use: a study of UK teenagers, *Drug and Alcohol Dependence*, 45, 1-2: 121-129.
- Mirin, S., Meyer, J., Mendelsohn, J. & Ellinghoe, J. (1980) Opiate use and sexual function, *American Journal of Psychiatry*, 137, 8: 909-915.
- Monaghan, L. F. (2001) *Bodybuilding, Drugs and Risk*. London: Routledge.
- Mondanaro, J.M. (1987) Strategies for AIDS prevention: motivating health behaviour in drug dependent women, *Journal of Psychoactive Drugs*, 19, 2: 143-149.
- Mondanaro, J. (1989) *Chemically Dependent Women: Assessment and Treatment*. Lexington: Lexington Books.
- Mondanaro J. (1990) Community-based AIDS prevention interventions: special issues of women intravenous drug users. In Leukefeld, C.G., Battjes, R.J. & Amsel, Z. (eds.) *AIDS and Intravenous Drug Users: Future Directions for Community-Based Prevention Research*. National Institute on Drug Abuse (NIDA) Research Monograph 93, Rockville, MD: US Department of Public health.
- Montgomery, S.B., Hyde, J., De Rosa, C.J., Rohrbach, L., Ehnett, S. *et al* (2002) Gender differences in HIV risk behaviours among young injectors and their social network members, *American Journal of Drug and Alcohol Abuse*, 28, 3: 453-475.
- Moore, S. & Rosenthal, D. (1993) *Sexuality in Adolescence*. London: Routledge.
- Morgan-Thomas, R., Plant, M.A., Plant, M.L. & Sales, D. (1989) Risks of AIDS among workers in the sex industry: Some initial results from a Scottish study, *British Medical Journal*, 229, 6692: 148-149.
- Morrison, C.L., Siney, C., Ruben, S.M. & Worthington, M. (1995) Obstetric Liaison in drug dependency, *Addiction Research* 3, 2: 93-101.
- Morrison, V. (1991) The impact of HIV upon injecting drug-users: a longitudinal study, *AIDS Care*, 3, 2: 193-201.
- Mort, M., Convery, I., Baxter, J. & Bailey, C. (2005) Psychosocial effects of the 2001 UK foot and mouth disease epidemic in a rural population: qualitative diary-based study, *British Medical Journal*, 331, 7527: 1234-1237.
- Mounteney, J. (1998) *Drugs, Pregnancy and Childcare: children of drug-using parents*, Highlight 163, London: National Children's Bureau.
- Mullender, A. (1996) *Rethinking domestic violence: the social work and probation response*. London: Routledge.
- Muller, R. & Boyle, J.S. (1996) "You don't ask for trouble": Women who do sex and drugs, *Family and Community Health*, 19, 3: 35-48.

Murphy, P.N. & Bentall, R.P. (1992) Motivation to withdraw from heroin: A factor analytic study, *British Journal of Addiction*, 87, 2: 245-250.

Murphy, S. (1987) Intravenous drug use and AIDS: notes on the social economy of needle sharing, *Contemporary Drug Problems*, 14: 373-395.

Murphy, S. & Rosenbaum, M. (1999) *Pregnant women on drugs: combating stereotypes and stigma*. New Brunswick: Rutgers University Press.

Najavits, L.M., Weiss, R.D., & Shaw, S.R. (1997) The link between substance misuse and post-traumatic stress disorder in women: a research review, *American Journal on Addictions*, 6, 4: 273-283.

National Institute for Health and Clinical Excellence (NICE) (2005a) Guidance on Depression in Young People [www.nice.org.uk/page.aspx?o=273073](http://www.nice.org.uk/page.aspx?o=273073) accessed on 26.10.2005.

National Institute for Health and Clinical Excellence (NICE) (2005b) Guidance on Long Acting Reversible Contraception [www.nice.org.uk/page.aspx?o=231933](http://www.nice.org.uk/page.aspx?o=231933) accessed on 26.10.2005.

National Treatment Agency for Substance Misuse (2002) *Models of Care for the Treatment of Adult Drug Misusers*. London: NTA.

Neaigus, A., Friedman, S.R., Curtis, R., Des Jarlais, D.C., Furst, R.T., Jose, B., Mota, P., Stephenson, B., Sufian, M. & Ward, T. (1994) The Relevance of Drug Injectors' Social and Risk Networks for Understanding and Preventing HIV Infection, *Social Science and Medicine*, 38, 1: 67-78.

Neaigus, A., Friedman, S.R., Goldstein, M., Edefonso, G., Curtis, R. & Jose, B. (1995) Using dyadic data for a network analysis of HIV infection and risk behaviour among injecting drug users. In R.H. Needle, S.L. Coyle, S.G. Genser & R.T. Trotter (eds.) *Social Networks: Drug Abuse and HIV Transmission*, NIDA Research Monograph 151. US Dept. of Health and Human Services.

Neaigus, A., Miller, M., Friedman, S.R., Hagen, D.L., Sifanock, S.J., Edefonso, G. & Des Jarlais, D.C. (2001) Potential risk factors for the transition to injecting among non-injecting drug users a comparison of former injectors and newer injectors, *Addiction*, 96, 6: 847-860.

Neale, J. (1998a) Reducing risks: drug users' views of accessing and disposing of injecting equipment, *Addiction Research*, 6, 2: 147-163.

Neale, J. (1998b) Drug users' views of prescribed methadone, *Drugs: Education, Prevention and Policy*, 5, 1: 33-45.

Neale, J. (1999) Experiences of illicit drug overdose: an ethnographic study of emergency hospital attendances, *Contemporary Drug Problems*, 26, 3: 505-530.

Neale, J. (2002) *Drug Users in Society*. Basingstoke: Palgrave.

Neale, J. (2004) Gender and illicit drug use, *British Journal of Social Work*, 34, 6: 851-870.

Newburn, T. & Pearson, G. (2002) *The place and meaning of drug use in the lives of young people in care*. London: University of London.

Newcombe, R. (1996) Live and let die. Is methadone more likely to kill you than heroin? *Druglink*, 11, 1: 9-12.

Nicolosi, A. (1990) Different susceptibility of women and men to heterosexual transmission of HIV, *VI International Conference on AIDS*, San Francisco (TIIC 585).

NCABS (2005) personal communication, North Cumbria Addictive Behaviours Service, staff team.

North Cumbria Primary Care Trust (NCPCT) (2004) *Shared Care Audit 2004*. Carlisle: NCPCT Clinical Effectiveness Group.

Nurco, D., Wegner, N. & Stephenson, P. (1982) Female narcotic addicts: changing profiles, *Journal of Addiction and Health: Focus on Women*, 2: 62-105.

Nurse, J., Garcia-Moreno, C., Phinney, A., Butchart, A. & Clarke, N. (2005) *A Global Perspective on Adolescent Sexual Relationship Violence: A New Understanding for Health Outcomes and Opportunities for Prevention*. Departments of Gender and Women's Health/Violence and Injury Prevention, Geneva: World Health Organisation.

Oakley, A. (1979) *Becoming a Mother*. Oxford: Martin Robertson.

Oakley, A. (1981) Interviewing women: A contradiction in terms. In H. Roberts (ed.) *Doing Feminist Research*. London: Routledge and Kegan Paul.

Oakley, A. (1987) Comment on Malseed, *Sociology*, 21, 4: 632.

Oakley, A. (1992) *Social Support and Motherhood: the natural history of a research project*. Oxford: Blackwell.

O'Brien, P.O. & McLellan, A.T. (1996) Myths about the treatment of addiction, *The Lancet*, 347, 8996: 237-240.

O'Connell, J.M., Kerr, T., Li, K., Tyndal, M.W., Hogg, R.S., Montaner, J.S. & Wood, E. (2005) Requiring Help Injecting Independently Predicts Incident HIV Infection Among Injection Drug Users, *Journal of Acquired Immune Deficiency Syndromes*, 4, 1: 83-88.

O'Hanlon, C., Teggin, B. & Walker, B. (2001) *Young people achieving their potential in rural Norfolk?* Norwich: Centre for Applied Research in Education, University of East Anglia.

O'Hara, M.W. & Swain, A.M. (1996) Rates and risk of post-partum depression - a meta-analysis, *International Review of Psychiatry*, 8, 1: 37-54.

O'Malley, P. & Valverde, M. (2004) Pleasure, freedom and drugs: The uses of pleasure in liberal governance of drug and alcohol consumption, *Sociology*, 38, 1: 25-42.

ODPM (2004) *The English Indices of Deprivation 2004 (revised)*. Report to the Office of the Deputy Prime Minister. Accessed online at [www.odpm.gov.uk](http://www.odpm.gov.uk) on 26 April 2005.

Office of National Statistics (2001) *Census Data: North West statistics accessed on 4 May 2004 at [www.statistics.gov.uk/census2001/pyramids/pages/b.asp](http://www.statistics.gov.uk/census2001/pyramids/pages/b.asp)*.

Office of National Statistics (2003) Household housing tenure data from Census2001 accessed on 4 May 2004 at [www.statistics.gov/CCI/nugget.asp?ID=358&Pos=6&colRank=1&Rank=224](http://www.statistics.gov/CCI/nugget.asp?ID=358&Pos=6&colRank=1&Rank=224)

Oppenheimer, E. (1994) Women drug misusers: a case for special consideration. In J. Strang & M. Gossop (eds.) *Heroin addiction and Drug Policy: The British System*. Oxford: Oxford University Press.

Orford, J., Rigby, K., Miller, T. & Tod, A. (1992) Ways of coping with excessive drug use in the family: A provisional typology based on the accounts of 50 close relatives, *Journal of Community and Applied Social Psychology* 2, 3: 163-183.

Ornoy, A., Michailevskaya, V., Lukaslov, I. *et al* (1996) The developmental outcome of children born to heroin-dependent mothers, raised at home or adopted, *Child Abuse and Neglect*, 20, 5: 385-396.

Padfield, M. & Procter, I. (1996) Effect of interviewer's gender on interviewing: a comparative inquiry, *Sociology*, 30, 2: 385-396.

Padian, N.S, O'Brien, T.R., Chang, Y., Glass, S. & Francis, D. (1993) Prevention of heterosexual transmission of HIV through couple counseling, *Journal of Acquired Immune Deficiency Syndrome*, 6, 9: 1043-1048.

Pandina, R.J. & Johnson, V. (1990) Serious alcohol and drug problems among adolescents with a family history of alcoholism, *Journal of Studies on Alcohol*, 51, 3: 278-282.

Paone, D., Chavkin, W., Willets, I., Freimann, P. & Des Jarlais, D. (1992) The impact of sexual abuse: Implications for drug treatment, *Journal of Women's Health*, 1, 2: 149-153.

Parker, H. & Measham, F. (1994) Pick 'n' Mix: changing patterns of illicit drug use among 1990s adolescents, *Drugs: Education, Policy and Prevention*, 1, 1: 5-13.

Parker H., Measham, F. & Aldridge, E.J. (1995) *Drugs Futures: Changing patterns of drug use amongst English Youth*, Research Monograph 7. London: ISDD.

Parker, H., Aldridge, J. & Measham, F. (1998) *Illegal leisure: The normalisation of adolescent recreational drug use*. London: Routledge.

Parker, H., Bakx, K. & Newcombe, R. (1988) *Living with Heroin: the impact of a drugs 'epidemic' on an English community*. Milton Keynes: Open University Press.

Payne, S. (1991) *Women, Health and Poverty: An introduction*. Hemel Hempstead: Harvester Wheatsheaf.

Pearson, G. (1987) *The New Heroin Users*. Oxford: Blackwell.

Perry, B. (1997) Incubated in terror: neuro-developmental factors in the 'cycle of violence'. In J. Osofsky (ed.) *Children, Youth and Violence: the search for solutions*. New York: Guilford Press.

Perry, L. (1979) *Women and Drug Use: an unfeminine dependency*. London: ISDD.

Pettitway, L.E. (1997) *"Workin' it": Women living through drugs and crime*. Philadelphia: Temple University Press.

Philip, K., Bruce, L. & Shucksmith, J. (1997) 'Doubly deviant?' Women drug injectors and their use of drug problem services. In P. Aggleton, G. Hart. & P. Davies (eds.) *AIDS: Activism and Alliances*. London: Taylor and Francis.

Phoenix, A. (1991) Mothers under twenty, insider and outsider views. In A. Phoenix, A. Woollett & E. Lloyd (eds.) *Motherhood, meanings, practices and ideologies*. London: Sage.

Plumridge, E. & Chetwynd, J. (1998) The moral universe of injecting drug users in the era of AIDS: sharing injecting equipment and protection of moral standing, *AIDS Care*, 10, 6: 723-733.

Pollack, M.H., Penava, S.A., Bolton, E., Wothington, J.J., Allen, G.L., Farach, F.J. & Otto, M.W. (2002) A novel cognitive behavioural approach for treatment-resistant drug dependence, *Journal of Substance Abuse Treatment*, 23, 4: 335-342.

Power, R.M. Hartnoll, R. & Daviaud, E. (1988) Drug injectors, AIDS and risk behaviour: potential for change and intervention, *British Journal of Addiction*, 83: 649-654.

Power, R., Jones, S., Kearns, G. & Ward, J. (1996) An ethnology of risk management amongst illicit drug injectors and its implications for the development of community-based interventions, *Sociology of Health and Illness*, 18, 1: 86-106.

Powis, B. (1995) Gender and Treatment: are equal numbers enough? *Addiction Counselling World*, January/February, 16.

Powis, B., Griffiths, P., Gossop, M. & Strang, J. (1996) The differences between male and female drug users: community samples of heroin and cocaine users compared, *Substance Use & Misuse*, 31, 5: 529-543.

Powis, B., Payne, B., Bury, C., Griffiths, P., Jacobs, B. & Strang, J. (1997) *An examination of the treatment needs of women opiate users with children: Final Report*. London: National Addiction Centre.

Powis, B., Griffiths, P., Gossop, M., Lloyd, C. & Strang, J. (1998) Drug use and offending behaviour among young people excluded from school, *Drugs: Education, Prevention and Policy*, 5, 3: 245-256.

- Powis, B. Gossop, M. Bury, C. Payne, K. Griffiths, P. (2000) Criminally involved drug-using mothers: social, psychological and substance use problems of women opiate users with children, *Drug and Alcohol Review*, 19, 2: 171-180.
- Price, R.K., Cottler, L.B., Magee, D. & Murray, K.S. (1995) Injecting drug use: characteristics of significant others and HIV risk behaviours. In R.H. Needle, S.L. Coyle, S.G. Genser & R.T. Trotter (eds.) *Social Networks: Drug Abuse and HIV Transmission. NIDA Research Monograph 151*. Rockville: US Dept. of Health and Human Services.
- Prins, E.H. (1995) *Maturing out: An empirical study of personal histories and processes in hard drug addiction*, Assen: Van Gorcum.
- Raine, P. (2001) *Women's perspectives on Drugs and Alcohol: the vicious circle*. Aldershot: Ashgate.
- Ramazanoglu, C. (1994) Theorizing Heterosexuality: A response to Wendy Hollway, *Feminism and Psychology*, 4, 2: 320-321
- Ramsay, M. & Spiller, J. (1997) *Drug Misuse Declared in 1996: latest results from the British Crime Survey Research Study 172*. London: Home Office.
- Ravndal, E. & Vaglum, P. (1994) Treatment of female addicts: the importance of relationships in parents, partners and peers for the outcome, *International Journal of the Addictions*, 29: 115-125.
- Reckman, L.W., Babcock, P. & O'Bryan, T. (1984) Meeting the childcare needs of the female alcoholic, *Child Welfare League of America*, 63, 6: 541-546.
- Reed, B.G. (1985) Drug misuse and dependency in women: the meanings and implications of being considered a special population or minority group, *International Journal of the Addictions*, 20, 1: 13-62.
- Reed, B.G. (1987) Developing women-sensitive drug dependence services: Why so difficult? *Journal of Psychoactive Drugs*, 19, 2: 151-164.
- Reinharz, S. (1992) *Feminist Methods in Social Research*. Oxford: Oxford University Press.
- Renzetti, C. & Lee, R. (1993) *Researching Sensitive Topics*. Newbury Park: Sage.
- Rhoads, D.L. (1983) A longitudinal study of life stress and social support amongst drug abusers, *International Journal of Addiction*, 18, 2: 195-222.
- Rhodes, T.J., Donoghoe, M.C., Hunter, G.M. & Stimson, G.V. (1993) Continued risk behaviour among HIV positive drug injectors in London: implications for intervention, *Addiction*, 88, 11:1553-1569.
- Rhodes, T.J., Donoghoe, M.C., Hunter, G.M., Soteri, A. & Stimson, G.V. (1994) Sexual behaviours of drug injectors in London: implications for HIV transmission and HIV prevention, *Addiction*, 89, 9: 1085-1096.

Rhodes, T. (1995) Theorizing and researching 'risk': notes on the sexual relations of risk in heroin users' lifestyles. In P. Aggleton, P. Davies & G. Hart (eds.) *AIDS: safety, sexuality and risk*. London: Taylor Francis.

Rhodes, T. & Hartnoll, R. (1996) *AIDS, Drugs and Prevention: Perspectives on Individual and Community Action*. London: Routledge.

Rhodes T. (1997) Risk theory in epidemic times: sex, drugs and the social organization of risk behaviour, *Sociology of Health and Illness*, 19, 2: 208-227.

Rhodes, T. & Quirk, A. (1998) Drug-users sexual relationships and the social organisation of risk: the sexual relationship as a site of risk management, *Social Science and Medicine*, 46, 2:157-169.

Rhodes, T., Stimson, G., Crofts, N., Ball, A., Dehne, K. & Khodakevich, L. (1999) Drug injecting, rapid HIV spread and the 'risk environment': implications for assessment and response, *AIDS*, (supplement A) 1: 259-269.

Rhodes, T. & Simic, M. (2005) Transition and the HIV risk environment, *British Medical Journal*, 331, 7510: 220-223.

Ribbens, J. (1994) *Mothers and their Children: A Feminist Sociology of Childrearing*. London: Sage.

Ribbens-McCarthy, J. & Jossop, J. (2005) *The impact of bereavement and loss on young people*, Joseph Rowntree Foundation Findings accessed on 15 June 2005 at [www.jrf.org.uk](http://www.jrf.org.uk)

Richardson, D. (1990) *AIDS Education and Women: Sexual and Reproductive Issues*. In P. Aggleton, P., Davies & G. Hart (eds.) *AIDS: Individual, Cultural and Policy Dimensions*. London: Falmer Press.

Ritter, A., Fry, C. & Swan, A. (2003) The ethics of reimbursing drug users for public health research interviews: what price are we prepared to pay? *International Journal of Drug Policy*, 14, 1:1-3.

Robbins, C. (1989) Sex differences in psychosocial consequences of alcohol abuse, *Journal of Health and Social Behaviour*, 30, 1:117-130.

Roberts, A., Jackson, M. & Carlton-Laney, I. (2000) Revisiting the need for feminism and Afrocentric theory when treating African-American female substance abusers, *Journal of Drug Issues*, 30, 4: 901-917.

Robertson, J.R. & Skidmore, C. (1989) Heterosexually acquired HIV infection (letter), *British Medical Journal*, 298, 6677: 891.

Root, M. (1989) Treatment failures: the role of sexual victimisation in women's addictive behaviour, *American Journal of Orthopsychiatrists*, 59, 4: 542-549.

Rosenbaum, M. (1979) Difficulties in taking care of business: women addicts as mothers, *American Journal of Drug and Alcohol Abuse*, 6, 4: 431-436.

Rosenbaum, M. (1981a) *Women on Heroin*. Brunswick, N.J.: Rutgers University Press.

Rosenbaum, M. (1981b) When drugs come into the picture love flies out of the window: Women addicts' love relationships, *International Journal of the Addictions*, 16, 7: 1197-1206.

Rosenbaum, M. & Murphy, S. (1984) Always a Junkie? The arduous task of getting off methadone maintenance, *Journal of Drug Issues*, 14, 4: 527-552.

Rosenbaum, M. & Murphy, S. (1990) Women and addiction: Process, treatment and outcomes. In L. Lambert (ed.) *The Collection of data from hidden populations*, NIDA Research Monograph 98. Rockwell: US Department of Health and Human Sciences.

Rosenbaum, M. (1997) Women, Research and Policy. In (eds.) J.H. Lowinson, C. Valenzuela, R.A. Ruiz, R.B. Millman & J.G. Langrod *Substance Abuse: A comprehensive textbook* (3rd edition). Baltimore: Williams & Wilkins.

Ross, H.E., Glaser, F.B. & Stiasny, S. (1988) Sex Differences in the Prevalence of Psychiatric Disorders in Patients with Alcohol and Drug Problems, *British Journal of Addiction*, 83, 10: 1179-1192.

Roth, P. (1991) *Alcohol and Drugs are Women's Issues* (volume 1), Metuchen New Jersey and London: Women's Action Alliance.

Rowan-Szal, G., Chatham, L., Joe, G.W. and Simpson, D.D. (2000) Services provided during methadone treatment: A gender comparison, *Journal of Substance Abuse Treatment*, 19, 1: 7-14.

Roy, E., Haley, N., Leclerc, P., Cedras, L. & Boivini, J. (2002) Drug injection among street youth: the first time, *Addiction*, 97, 8: 1003-1009.

Rural Regeneration Cumbria (2002) Cumbria Rural Action Zone Strategy accessed online April 2005 at [www.ruralcumbria.co.uk](http://www.ruralcumbria.co.uk)

Russell, P. (2006) *Have We Got Our Priorities Right? Children living with parental substance use*. Stirling: Aberlour Child Care Trust.

Russell, S. & Wilsnack, S. (1991) Adult survivors of childhood sexual abuse. In P. Roth. (ed.) *Alcohol and Drugs are Women's Issues* (volume 1). Metuchen New Jersey: Women's Action Alliance.

Sarafino, E.P. (1990) *Health psychology: Bio-psychosocial interactions*. New York: Wiley.

Sargent, C. (1992) *Women, Drugs and Policy in Sydney, London and Amsterdam: a feminist interpretation*. Aldershot: Avebury.

Schliebner, C.T. (1994) Gender-sensitive therapy: an alternative for women in substance abuse treatment, *Journal of Substance Abuse Treatment*, 11, 6: 511-515.

Schools Health Education Unit (SHEU) (2005) *Drug use in Cumbria: are smoking, drinking and experimentation with illegal drugs linked?* Exeter: SHEU.

Schutz, A. (1970) *Reflections on the Problem of Relevance*. New Haven and London: Yale University Press.

Scott, M. & Lyman, S. (1968) Accounts, *American Sociological Review*, 33, 1: 46-62.

Scottish Drugs Forum (1997) *Drug use in rural areas: policy statement*. Glasgow: SDF.

Scottish Executive (2003) *Getting our Priorities Right: Policy and Practice Guidelines for Working with Children and Families Affected by Problem Drug Use*. Edinburgh: Scottish Executive.

Seligman, M. & Maier, S. (1967) Failure to escape traumatic shock, *Journal of Experimental Psychology*, 74, 1: 1-9.

Sheehan, M., Oppenheimer, E. & Taylor, C. (1988) Who comes for treatment?: drug misusers at three London agencies, *British Journal of Addiction*, 83, 3: 311-320.

Shucksmith, M. (2004) Young people and social exclusion in rural areas, *Sociologia Ruralis*, 44: 43-49.

Sibthorpe, B. (1992) The social construction of sexual relationships as a determinant of HIV risk perception and condom use among injection drug users, *Medical Anthropology Quarterly*, 6, 3: 255-270.

Simpson, D.D., Joe, G.W., Rowan-Szal, G. & Greener, J. (1995) Client engagement and change during drug abuse treatment, *Journal of Substance Abuse*, 7, 1: 117-134.

Siney C. (1995) *The Pregnant Drug Addict*. Hale, Cheshire: Books for Midwives Press.

Siney, C., Kidd, M., Walkingshaw, S., Morrison, C. & Manasse, P. (1995) Opiate Dependency in Pregnancy, *The British Journal of Midwifery*, 3: 69-73.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A & Meltzer, H. (2001) *Psychiatric morbidity among adults living in private households*. London: The Stationery Office.

Small, R., Brown, S., Lumley, J. & Adstbury, J. (1994) Missing voices: What women say and do about their depression after childbirth, *Journal of Reproductive and Infant Psychology*, 12, 2: 89-104.

Smith, D. (1988) *The Everyday World as Problematic: A Feminist Sociology*. Milton Keynes: Open University Press.

Smith, D.E., Moser, C., Wesson, D.R., Apter, M., Buxton, M.E., Davison, J.V., Orgel, M. & Buffum, J. (1982) A clinical guide to the diagnosis and treatment of heroin-related sexual dysfunction, *Journal of Psychiatric Drugs*, 14, 1-2: 91-99.

Smithberg, N. & Westermeyer, J. (1985) White dragon pearl syndrome: a female pattern of drug dependence, *American Journal of Drug and Alcohol Abuse*, 11, 3-4: 199-207.

Social Exclusion Unit (SEU) (2004) *Breaking the Cycle: taking stock of progress and priorities for the future*. London: Office of the Deputy Prime Minister.

Social Exclusion Unit (SEU) (2005) *Transitions: young adults with complex needs*. London: Office of the Deputy Prime Minister.

Sondhi, A., O'Shea, J. & Williams, T. (2002) *Arrest Referral: emerging findings from the national monitoring and evaluation programme*. London: Research Statistics Directorate, Home Office.

South, N. (1999) Debating Drugs and Everyday Life: Normalisation, Prohibition and Otherness. In N. South, (ed.) *Drugs: Cultures, Controls and Everyday Life*. London: Sage.

Sparey C. & Walkinshaw S. (1995) Obstetric problems for drug users. In C. Siney (ed.) *The Pregnant Drug Addict*. Hale, Cheshire: Books for Midwives Press.

Spittal, P., Craib, K., Wood, E., Laliberte, N., Li, K., Tyndall, M., O'Shaughnessy, M. & Schechter, M. (2002) Factors for Elevated HIV Incidence Rates Among Female Injection Drug Users in Vancouver, *Canadian Medical Association Journal*, 166, 7: 894-903.

Spradley, J. (1979) *The Ethnographic Interview*. New York: Holt, Rinehart & Winston.

Stall, R. and Biernacki, P. (1986) Spontaneous remission from the problematic use of substances: An inductive model derived from a comparative analysis of the alcohol, opiate, tobacco, and food/obesity literatures, *The International Journal of the Addictions*, 21, 1: 1-23.

Stanko, E.A. (1985) *Intimate Intrusions: Women's experiences of Male Violence*. London: Routledge & Kegan Paul.

Stark, M.J. (1992) Dropping out of substance abuse treatment: a clinically oriented review, *Clinical Psychology Review*, 12, 1: 93-116.

Steffen, T., Christen, S., Blattler, R. & Gutzwiller, F. (2001) Infectious diseases and public health: risk-taking behavior during participation in the Swiss program for a medical prescription of narcotics (PROVE), *Substance Use and Misuse*, 36, 1-2: 71-89.

Steffensmeier, D. & Streifel, C. (1993) Trends in female crime 1960-1990. In C. Culliver (ed.) *Female criminality: The state of the art*. New York: Garland.

Stein, M.D., Charuvastra, A. & Maksad, J. (2002) A randomized trial of a brief alcohol intervention for needle exchangers (BRAINE), *Addiction*, 97, 6: 691-700.

Stella Project (2004) *Domestic violence, drugs and alcohol: good practice guidelines*. London: The Stella Project.

Sterk, C.E. (1999) *Fast Lives, Women who use Crack Cocaine*. Philadelphia: Temple University Press.

Sterling R.C., Gottheil, E., Weinstein, P. & Serota, R. (2001) The effect of therapist/patient race- and sex-matching in individual treatment, *Addiction*, 96, 7: 1015-1022.

Stewart, A. (2000) *Where is she tonight? Women, street prostitution and homelessness in Glasgow. Research conducted within Base 37 Drop-in Centre*. Glasgow: Rough Sleeping Initiative.

Stewart, D., Gossop, M., Marsden, J., Kidd, T., & Treacy, S. (2003) Similarities in outcomes for men and women after drug misuse treatment: results of the National Treatment Outcomes Research Study (NTORS), *Drug and Alcohol Review*, 22, 1: 35-41.

Stevens, S.J., Tortu, S. & Coyle, S.L. (1998) Women Drug Users and HIV Prevention: Overview of Findings and Research Needs. In S.J. Stevens, S. Tortu & S.L. Coyle (eds.) *Women, Drug Use and HIV Infection*. New York: The Haworth Press.

Stewart, S.H., Pihl, R.O., Conrod, P.J. & Dongier, M. (1998) Functional associations among trauma, PTSD and substance-related disorders, *Addictive Behaviours*, 23, 6: 797-812.

Stimson, G. (1987) The war on heroin: British policy and the international trade in illicit drugs. In N. Dorn & N. South (eds.) *A Land fit for Heroin Drug policies, prevention and practice*. London: Macmillan.

Stimson, G.V. (1996) Has the United Kingdom averted an epidemic of HIV-1 infection among drug injectors? *Addiction*, 91, 8: 1085-1099.

Stimson, G. & Oppenheimer, E. (1982) *Heroin addiction: Treatment and Control in Britain*. London: Tavistock.

Stimson, G.V. & Aldritt, L.J. (1988) *Injecting Equipment Exchange schemes: Final Report to the Department of Health*. London: Goldsmiths College, The Centre for Research on Drugs and Health Behaviour.

Stimson, G. & Metrebian, N. (2003) *Prescribing heroin: what is the evidence?* York: Joseph Rowntree Foundation.

Stockdale, A. (2002) Outmigration from rural Scotland: The importance of family and social networks, *Sociologia Ruralis*, 42: 43-59.

Stoneburner, R., Chaisson, M.A., Weifuse, I. & Thomas, P.A. (1990) The epidemic of AIDS and HIV-1 in New York City, *AIDS*, 4, 2: 99-106.

Strang, J. Best, D., Ridge, G. & Gossop, M. (2004) *Randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate users awaiting out-patient treatment*, Research Summary 3. London: National Treatment Agency.

Suffet, F. & Brotman, R. (1976) Female drug use: some observations, *International Journal of Addiction*, 11, 1: 19-33.

Sudman, S. & Kalton, G. (1986) New developments in the sampling of special populations, *Annual Review of Sociology*, 12: 401-429.

Sudman, S., Sirken, M. & Cowan, C. (1988) Sampling rare and elusive populations, *Science*, 240, 4855: 991-996.

Sumnall, H., Jones, L., Burrell, K., Witty, K., McVeigh, J. & Bellis, M. (2006) *Annual Review of Drug Prevention*, Liverpool: National Collaborating Centre for Drug Prevention, Liverpool John Moores University.

Sutton, A. (2006) A 'model' Prison Intervention, *Infection Inside: The Prison Infectious Diseases Quarterly*, February 2006, 2, 1: 2.

Swadi, H. (1994) Parenting capacity and substance misuse: an assessment scheme, *Association of Child Psychology and Psychiatry Newsletter*, 16: 237-245.

Swift, W., Copeland, J. & Hall, W. (1996) Characteristics of women with alcohol and other drug problems: Findings of an Australian national survey, *Addiction*, 91, 8: 1141-1150.

Tajfel, H. (1978) *The Social Psychology of Minorities*. London: Minority Rights Group.

Taket, A.R., Nurse, J., Smith, K. et al (2003) Routinely screening women about domestic violence in the health setting, *British Medical Journal*, 327, 7416: 673-676.

Task Force to Review Services for Drug Misusers (1996) *Report of an independent review of drug treatment services in England*. London: Department of Health.

Taylor, A. (1993) *Women Drug Users: An ethnography of a female injecting population*. Oxford: Clarendon Press.

Taylor, A., Goldberg, D., Hutchinson, S., Cameron, S., Gore, S.M., McMenamin, J., Green, S., Pithie, A., & Fox, R. (2000) Prevalence of hepatitis C virus infection among injecting drug users in Glasgow 1990-1996: Are current harm-reduction strategies working? *Journal of Infection*, 40, 2: 176-183.

Taylor, S.J. & Bogdan, R. (1984) *Introduction to Qualitative Research Methods: The search for meanings*. New York: Wiley.

Thom, B. (1986) Sex Differences in Help-Seeking for Alcohol Problems - 1. The Barriers to Help-Seeking, *British Journal of Addiction*, 81: 777-788.

Thom, B. & Green, A. (1996) *Services for women: the way forward*. In L. Harrison (ed.) *Alcohol problems in the community*. London: Routledge.

Thompson, J. (2004) Pregnancy and domestic violence, *Community Practitioner*, 77, 5: 192-193.

Timimi, S. (2004) Rethinking childhood depression, *British Medical Journal*, 329, 7479: 1394-1396.

Timms, R. (2005) Mentor Grandparents project, *Drugs Prevention, National Collaborating Centre for Drugs Prevention*, September, 3:10.

Trace, M., Riley, D. & Stimson, G. (2005) *UNAIDS and the prevention of HIV infection through injecting drug use, Briefing Paper 9*, The Beckley Foundation Drug Policy Programme accessed on 28 December 2005 at [www.beckleyfoundation.org/pdf/paper\\_09.pdf](http://www.beckleyfoundation.org/pdf/paper_09.pdf)

Tun, W., Celentano, D.D., Vlahov, D. & Strathdee, S.A. (2003) Attitudes towards HIV treatments influence unsafe sexual and injection practices among injecting drug users, *AIDS*, 17, 13: 1953-1962.

Turnbull, P. (1999) *Drug Treatment and Testing Orders: Interim evaluation. Home Office Research Findings 106*, London: Home Office.

Tyler, R., Howard, J., Espinosa, M., Simpson Doakcs, S. (1997) Placement with substance-abusing mothers vs placement with other relatives: infant outcomes, *Child Abuse and Neglect*, 21, 4: 337-349.

United Kingdom Alcohol Treatment Trial (UKATT) Research Team (2001) Hypotheses, Design and Methods, *Alcohol and Alcoholism*, 36, 1: 11-21.

Underhill, B.L. (1986) Issues relevant to aftercare programs for women, *Alcohol, Health and Research World*, 11: 46-47.

UNODC (2005) *World Drug Report 2005* accessed at [http://www.unodc.org/unodc/world\\_drug\\_report\\_2005.html](http://www.unodc.org/unodc/world_drug_report_2005.html) on 28<sup>th</sup> December 2005.

Unger, J.B., Kipke, M.D., Simon, T.R., Johnson, C.J., Montgomery, S.B. & Iverson, E. (1998) Stress, Coping and Social Support Among Homeless Youth: Correlates of Depression, Self-rated Health, and Substance Use, *Journal of Adolescent Research*, 13, 2: 134-157.

Ussher, J. (1998) A Feminist Perspective. In R. Velleman, A. Copello & J. Maslin (eds.) *Living with Drink: Women who live with Problem Drinkers*. Longman: London.

Valente, T.W. (1995) *Network Models of the Diffusion of Innovation*. Cresskill, NJ: Hampton Press.

Van Beek, I., Dwyer, R., Dore, G.J., Luo, K. & Kaldor, J.M. (1998) Infection with hepatitis C virus among injecting drug users in a prevention setting: retrospective cohort study, *British Medical Journal*, 317, 7156: 433-437.

Vance, C. (1984) Pleasure and danger: towards a politics of sexuality. In C. Vance (ed.) *Pleasure and Danger: Exploring Female Sexuality*. London: Routledge and Kegan Paul.

Van Etten, M.L. & Anthony, J.C. (1999) Comparative epidemiology of initial drug opportunities and transitions to first use: marijuana, cocaine, hallucinogens and heroin, *Drug & Alcohol Dependence*, 54, 2: 117-125.

- Velleman, R., Bennett, G., Miller, T., & Orford, J. (1993) The families of problem drug users: A study of 50 close relatives, *Addiction*, 88, 9: 1281-1289.
- Velleman, R. & Orford, J. (1999) *Risk and Resilience: adults who were the children of problem drinkers*. Amsterdam: Harwood Academic.
- Vento, S., Nobile, V. & Kinelli, F. (2006) Clinical course of infection with hepatitis C, *British Medical Journal*, 332, 7538: 374-375.
- Vidal-Trécan, G., Coste, J., Coeuret, M., Delamare, N., Varescon-Pousson, I. & Boissonnas, A. (1998) Risk behaviours of intravenous drug users: are females taking more risks of HIV and HCV transmission? *Revue Epidemiologie et Sante Publique*, 46:193-204.
- Vidal-Trécan, G., Varescon-Pousson, I., Boissonnas, A. (2002) Injection risk behaviours at the first and at the most recent injections among drug users, *Drug and Alcohol Dependence*, 66, 2: 107-109.
- Vitellone, N. (2003) The syringe as prosthetic, *Body and Society*, 9, 3: 37-52.
- Vogt, I. (1998) Gender and drug treatment systems. In H. Klingemann & G. Hunt (eds.) *Drug Treatment systems in an International Perspective: Drugs, Demons and Delinquents*. London: Sage.
- Wanigaratne, S., Davis, P., Pryce, K. & Brotchie, J. (2005) *The effectiveness of psychological therapies on drug misusing clients*, *Research Briefing 11*. London: National Treatment Agency for Substance Misuse.
- Ward, J. (1998) Substance misuse among young people 'Looked After' by Social Services, *Drugs: Education, Prevention and Policy*, 5, 3: 257-267.
- Ward, J., Henderson, Z. & Pearson, G. (2003) *One problem among many: drug use among care leavers in transition to independent living*. London: Home Office Research, Development and Statistics Directorate.
- Waterson, J. & Ettorre, B. (1989) Providing services for women with difficulties with alcohol or other drugs: The current UK situation as seen by women practitioners, researchers and policy makers in the field, *Drug and Alcohol Dependence*, 24, 2: 119-125.
- Wax, R.H. (1979) Gender and age in fieldwork and fieldwork education: No good thing is done by any man alone, *Social Problems*, 26, 5: 509-522.
- Weaver, T., Stimson, G., Tyrer, P., Barnes, T. & Renton, A. (2004) What are the implications for clinical management and service development of prevalent co-morbidity in UK mental health and substance misuse treatment populations? *Drugs: Education, Policy & Prevention*, 11, 4: 329-348.
- Weeks, M., Grier, M., Romero-Daza, N., Puglisi-Vasquez, & M. Singer, M. (1998) Streets, drugs and economy of sex in the age of AIDS, *Women and Health*, 27, 1-2: 205-229.

- Wellisch, D.K., Gay, G.R. & McEntee, R. (1970) The Easy Rider Syndrome: A Pattern of Hetero- and Homosexual Relationships in a Heroin Addict Population, *Family Process*, 9, 4: 425-430.
- West, M.O. & Prinz, R.J. (1987) Parental alcoholism and childhood psychopathology, *Psychological Bulletin*, 120, 2: 204-218.
- West Cumbria Strategic Partnership (2006) *Sustainable Community Strategy (Draft)*, Workington: Allerdale Borough Council.
- White, D., Phillips, K., Mulleady, G. & Cupitt, C. (1993) Sexual issues and condom use among injecting drug users, *AIDS Care*, 5, 4: 427-437.
- Wight, D. (1999) Cultural factors in young heterosexual men's perception of HIV risk, *Sociology of Health and Illness*, 21, 6: 735-758.
- Wilkinson, S. & Kitzinger, C. (1996). *Representing the Other*. London: Sage.
- Wilson, J. (1997) The emergence of CSA Issues in Drug and Alcohol Services: Research Findings. In *The Connection: Proceedings of a Conference on Childhood Sexual Abuse and Drug Dependence*, University of Stirling: Scottish Drugs Training Project.
- Wister, A.V. & Avison, W.R. (1982) Friendly Persuasion: A Social Network Analysis of Sex Differences in Marijuana Use, *International Journal of the Addictions*, 17, 3: 523-541.
- Witton, J. & Ashton, M. (2004) *Engaging and retaining clients in drug treatment, Research into Practice Briefing 5*. London: National Treatment Agency.
- Wodak, A. & Crofts, N. (1996) Once more into the breach: Controlling hepatitis C in injecting drug users, *Addiction*, 91, 2: 181-184.
- Women's Aid (2003) *What is Domestic Violence?* Accessed online on 16 March 2005 at [www.womensaid.org.uk](http://www.womensaid.org.uk)
- Wood, E., Spittal, P., Kerr, T., Small, W., Tyndall, M., O'Shaughnessy, M. & Schechter, M. (2003a) Requiring help Injecting as a risk factor for HIV Infection in the Vancouver Epidemic – Implications for HIV prevention, *Canadian Journal of Public Health*, 94, 5: 355-359.
- Wood, E., Kerr, T., Spittal, P., Small, W., Tyndall, M., O' Shaughnessy, M. & Schechter, M. (2003b) An External Evaluation of a peer-run 'Unsanctioned' Syringe Exchange Program, *Journal of Urban Health*, 80, 3: 455-465.
- Woodward, L.J. & Fergusson, D.M. (2001) Life course outcomes of young people with anxiety disorders in adolescence, *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 9: 1086-1093.
- World Health Organisation (1997) *Violence against women: a health priority issue*. Accessed on 28 December 2005 at [www.who.int/gender/violence/vawpriority/en/](http://www.who.int/gender/violence/vawpriority/en/)

World Health Organisation (2000) 'Hepatitis C'; *Fact Sheet No 164*. Accessed on 15 June 2005 at <http://www.who.int/mediacentre/factsheets/fs164/en/>

World Health Organisation (2004) WHO/UNODC/UNAIDS position paper - *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Accessed on 15 June 2005 at [http://www.who.int/substance\\_abuse/publications/treatment/en/](http://www.who.int/substance_abuse/publications/treatment/en/)

Wright, S. (2002) Women's use of drugs: gender-specific factors. In H. Klee, M. Jackson & S. Lewis. (eds.) *Drug Misuse and Motherhood*. London & New York: Routledge.

Wright, S. & Klee, H. (2000) Developing drug services for amphetamine users: taking account of gender-specific factors, *Journal of Substance Use*, 5, 2: 122-130.

Yeung, L.T.F. (2001) Mother to infant transmission of hepatitis C virus, *Hepatology*, 34, 2: 223-229.

Young Women's Christian Association (YWCA) (2002) *Beyond the bus shelter: Young women's choices and challenges in rural areas*. Oxford: YWCA.

Young, R. (2002) *From war to work: drug treatment, social exclusion and enterprise*. London: The Foreign Policy Centre.

Ziberman, M., Tavers, H. & Guebaly, V. (2003) Gender similarities and differences: the prevalence and course of alcohol and other substance-related disorders, *Journal of Addictive Diseases*, 22, 4: 61-74.

Zubretsky, T. (2002) Promising directions for helping chemically involved battered women get safe and sober. In A. Roberts (ed.) *Handbook of domestic violence intervention strategies: Policies, programs and legal remedies*. Oxford: Oxford University Press.

Zule, W.A. (1992) Risk and reprecocity: HIV and the injecting drug user, *Journal of Psychoactive Drugs*, 24, 3: 243-249.

