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Brown, Josef W. (2024) *An ethnographic exploration of the everyday lives of 51 people with heroin use experience in rural Dumfries and Galloway, Scotland.* PhD thesis.

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An Ethnographic Exploration of the Everyday Lives of 51 People with Heroin Use Experience in Rural Dumfries and Galloway, Scotland.

By

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Submitted in fulfilment of the requirements of the degree of Doctor of Philosophy

School of Social and Political Sciences

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University of Glasgow

September 2022

Changes and Corrections

June 2024

Abstract.

Scotland has a profound public health crisis related to drug use with the unenviable position of holding the highest drug related deaths rate in Europe. Approximately two to three people die from drug use every day in Scotland. The gravity of this situation warrants immediate, comprehensive and efficacious strategies to address the underlying factors that are contributing to this national crisis. One-fifth of people who use heroin in Scotland live in rural areas. Prevailing research exploring heroin use, however, focuses mainly on urban contexts. This thesis explores the "everyday lives" of rural people who use heroin within context and framework of the then Scottish Drugs Policy, "*The Road to Recovery*" (2008-2018) (Scottish Government, 2008). It investigates and scrutinises how people who use heroin in a rural setting acquire, administer and finance their heroin use, illuminating the significance of "recovery" from their perspectives. Examining the experiences of people who use heroin within a rural setting, provides an avenue to comprehend how aspects of rural living, such as transportation challenges, employment dynamics and lack of anonymity inherent within rurality, impact, shape and influence their daily realities. People who engage with heroin use in rural settings are notoriously difficult to locate and involve, posing challenges not only for research but policy development and practical interventions specifically targeted at their requirements given the background of the public health crisis.

This thesis presents the findings of a year-long ethnographic research study conducted throughout 2018 in rural Dumfries and Galloway in South-West Scotland. The study employed nonparticipant observation, participant-observation, field notes, and interviews involving 51 people who used heroin and 20 recovery service staff. Braun and Clark's (2006, 2019) reflexive thematic analysis framework was adopted and adapted to analyse my data, the research aim was to determine how this group perceived their everyday role and place within their rural communities. It explored the unique challenges and opportunities inherent in a rural setting and investigated what recovery means to people who actively use heroin through their lived realities. The analysis uncovered the distinctive and unique experiences of people who use heroin in rural Dumfries and Galloway, highlighting the challenges and opportunities that presented in relation to substance use and recovery. These experiences frequently contradicted themes identified in research undertaken in urban settings.

The findings indicate that participants did not problematise heroin use. Instead, their heroin use was characterised by a high degree of regulation, evidenced from the findings. Regulated

heroin use was shaped by accessible and free methadone maintenance treatment prescriptions and the presence of sympathetic and supportive staff within drug recovery services. Their familiarity within their wider communities shielded them in the main from feeling stigmatised and promoted inclusivity and even protection. Exploring this group's everyday lives uncovered that they were not solely people who engaged with heroin use; they were also employees, partners, friends, and parents, who perceived their lives as "normal", functional, content and fulfilling despite their long-term heroin use. Without exception they clarified that they were not seeking recovery in the form of abstinence. Instead, they engage with recovery services to access prescription methadone and other benefits provide by these services. Recovery services capitalised on these opportunities to engage in health promotion and education with their "clients."

Similarities to urban settings were also observed, including similar numbers of people who used heroin per capita, increased poly-drug use, overdose incidents, and increasing drug-related deaths. Distinctive factors were also noted, such as negligible homelessness, widespread adoption of naloxone kits and training, reported low purity of heroin, a high proportion of older people who used heroin, rejection of public heroin use and communal environments during heroin use. Unexpected findings extended to the accessibility of heroin even within the remotest of areas, regulated and controlled use of heroin, reliance on state benefits rather than criminality for cash generation, a decline in heroin use and limited recovery services operating within traditional 9-5 hours five days per week. This thesis makes a meaningful contribution to the literature by exploring the everyday lived experiences of people who use heroin, identifying the unique challenges and opportunities associated with rural substance use and recovery highlighting a new concept termed "recovery inertia". Above all, it offers a voice to an overlooked and unrepresented population.

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Acknowledgements

My sincere gratitude goes to the participants of my study who kindly and warmly invited me into their lives, their homes and generously shared their thoughts and time with me. Too many of my participants have sadly passed away and I hope that I represent their voices as they would have wanted. I would also like to extend my thanks to all the staff of the NHS Dumfries and Galloway Specialist Drug and Alcohol Service for their time, help and support.

To my supervisors Dr Lucy Pickering and Dr Susan Batchelor who have *endured* my studentship with fortitude and who have taught me more than they will ever know, not just about social science and academia but also about humanity, I will use this always, thank you both. To the inspirational Professor Sally Wyke, my heartfelt thanks, and the late Dr Nicole Bourque for her insight, wise words and guidance. I would also like to extend my gratitude to the many administrative staff at the University of Glasgow for their assistance as I bumbled my way around form filling and applications.

To my best friends, Steve, Barry, Dave, Gordon and Kevin who sat listening to my curmudgeonly ravings at all hours, their support never faltered and not once a negative word was uttered.

Finally, to my long-suffering wife Liz and my wonderful, inspiring and infuriating offspring Jack, Fluff and (*especially*) Tommo, my love and eternal gratitude.

Dedicated to my "faither" Wullie "Saughton" Broon (1934-2019), my father-in-law and dear friend Derek "Par" Fulton (1930-2017) and my beloved mother-in-law Betty "Mar" Fulton (1932-2020), I miss you all.

Author's declaration

To the best of my knowledge, no portion of this thesis contains or has been previously used by myself or anyone else for any other purpose except where I have acknowledged this within the text. No material within this thesis has been used and accepted for any other award in any university or educational institute.

Name: Josef W. Brown.

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Date: 29th of September 2022.
Date: 25th of September 2023 (Changes and corrections).
Date: 24th of June 2024 (Changes and corrections).

Chapter 1: Introduction

1. Overview.

My thesis is concerned with people who actively use heroin in rural Dumfries and Galloway, Scotland. It focuses on those who actively use heroin in rural settings for the following reason: a historical lack of research into rural heroin use, the people who use it and their associated recovery. This point has been identified as far back as 1977 by Brown et al. (1977) and later amplified by authors such as Lenardson, et al. (2016), who also found that research on drug use and recovery for populations between 20,000 and 50,000 (cited as "almost rural areas") is limited because people who use heroin are geographically diverse in rurality, and that, furthermore, people who use heroin within a rural setting, due to the illicit and illegal nature of heroin, are both secretive and exceedingly difficult to locate and then engage. Many studies engage participants who are "recovered" or "in recovery" from heroin and other drug use, drawn primarily from urban areas where they are easy to locate and engage in research. I, however, specifically set out to understand the everyday lives and practices of people who actively use heroin in a rural setting, and what meaning recovery has for them in the context of the Scottish Government's 2008-2018 drugs strategy, *The Road to Recovery*.

This first chapter presents the background to my study; in subsequent sections I shall explore and explain the justification, significance, and relevance for choosing my topic, setting out its inception and development from my initial considerations and thoughts. I shall argue why this thesis is pertinent, necessary, and compelling, and explain its value as I comprehensively explore associated research, literature and analysis within the literature review chapters. In drafting this thesis, I draw upon sociological perspectives from historical and contemporary writings by prominent sociologists, but where necessary I also explore and draw upon evidence from other disciplines. I initially present and explain my aims and consequent research objectives within this chapter and then more fully in my methods chapter. The analysis chapters that follow are designed to address my thesis aim and objectives highlighting any associated empirical weaknesses I have found within the literature, culminating in an original and unique contribution to knowledge and research in this area.

1.1 Background- Policy development.

The origins of my thesis began somewhat tangentially with the *Rights, Relationships and Recovery* mental health strategy enacted by the Scottish Government in 2007, a strategy

developed to provide equality and inclusion for people with mental health issues in Scotland. As a recovery-focused strategy, it was a seaward change to the previous model as it was specifically developed to be inclusive and person-centred, drawing guidance and input from people with mental health issues and their significant others from communities throughout Scotland. Personal journeys, individual voices, and expertise informed and shaped the strategy, which embraces and promotes person-centred care, inclusiveness and recovery focus. It superseded the incumbent (if arguably outdated) medical model which framed mental ill health within a disease process excluding an individual's lived expertise, unique journey, and individual needs.

The Rights, Relationships and Recovery (2007) strategy advocates that recovery from mental health illness no longer requires the absence (i.e. removal) of mental ill health. Recovery was reconsidered and redefined within mental health parameters as: "A long-term process or "journey" not simply the absence of symptoms" (Scottish Executive, 2006, p.11). This means people should be supported to live the "best life" that they can, with their (mental) "illness," within their communities, whilst receiving ongoing support where and when necessary. The identification and development of a person's "strengths" were prioritised, highlighted, and developed, rather than identifying and concentrating on perceived "weaknesses," many of which are irresolvable. Mental health recovery affirms people can live rich, normal, and fulfilling lives, regardless of ongoing or chronic mental ill health.

One year later, *The Road to Recovery* (2008-18) drugs strategy was developed and implemented to address Scotland's longstanding and ongoing problematic relationship with "addiction" to illicit drugs such as heroin and licit alcohol. This strategy, however, is less strengths-based or optimistic by implying that drug use is problematic, people who use drugs are a danger to themselves and others, that they are inactive, non-contributing members of Scottish society who are either unemployed or unemployable, who live in the *most* deprived areas and are a drain on public resources. The United Nations Office on Drugs and Crime (2012) cites that Scotland presents the highest levels of substance misuse in the Western world. Public Health Scotland (PHS) (2019) estimated that in 2018, 1% of the Scottish population, (approximately 60,000 people), were "addicted" to an opiate-based drug (i.e., heroin and/or methadone) and/or illicit benzodiazepine (i.e., diazepam and alprazolam). Scotland's drug-related mortality (1,264 in 2019, 1,339 in 2020, 1,330 in 2021) (PHS, 2021) represents the highest in Europe per capita and 3.5 times higher than the rest of the United Kingdom and is

considered a national public health issue. The reasons for this are contested and not fully understood, although they are identified as "multi-faceted" (PHS, 2021).

To understand Scotland's relationship with drug use and associated drug related deaths, it is important to give a brief background to their development, although I will explore this more fully later (within my thesis). Before the 1960s, illicit opiate use such as heroin within the United Kingdom (U.K.) was considered the domain of urban, older middle-class males, individuals often associated with bohemian lifestyles such as musicians, artists and writers (Brown, et al. 1977). By the late 1960s, heroin use began a slow shift towards younger populations and impoverished urban communities within London, before spreading to other urban centres throughout the U.K. such as Glasgow. Crucially, opiate addiction throughout the U.K. at this time was counted in the low hundreds of people; the relatively small numbers meant that it was not considered a public health concern or threat to wider society. Drug use, however, was undoubtedly on the increase at that time. The Misuse of Drugs Act (1971) was intended primarily to eradicate drug use in U.K. society through prohibition and criminalisation of illicit opiates such as heroin and those people who used them. Criminalisation led to people who used drug to be ostracised and marginalised by the political establishment and subsequently members of society who did not use illicit drugs. So-called heroin "addicts" were pushed to the margins of society to conduct their illicit activities in secrecy to avoid the criminal justice system and law-abiding public. Forsyth and Barnard (1999), Parker, et al. (1988) and Pearson (1987) posit that a populist belief that arose at this time was that impoverished urban youth became representative of the archetypal "heroin addict." Reinforced by popular media, this image is now so well ingrained in the U.K. population psyche that it perpetuates the notion to this day that heroin use is solely an urbanised phenomenon, a notion which is explored later in my thesis.

The U.K. Government's response to increasing drug use was an ongoing "crackdown" on people who used drugs and their associated activities, underpinned by a stringent application of the Misuse of Drugs Act (1971) by the criminal justice system. A war on drugs had begun in earnest. In the 1980s, however, the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic rapidly changed the political landscape within the U.K. A high prevalence of HIV and AIDS among needle-sharing people who used heroin sparked a fear of HIV and AIDS being transmitted to and amongst the general population. Societal fear instigated political intervention to contain the epidemic within the drug-using

population. Harm reduction measures, pragmatically applied to people who used opiates until that point, were now rigorously and broadly implemented within urban epicentres of drug use. These were spearheaded by National Health Service (NHS) mental health workers such as the writer, who witnessed first-hand the impact HIV and AIDS had not only on the intravenous drug-using community, but also gay men, in inner-city Edinburgh.

Harm reduction (which I shall return to later) extended to free needle exchange, sterile equipment (needles, condoms), health education (blood borne virus (BBV) testing) and pharmaceutical substitutes i.e., oral methadone. It was not devised, however, to work in tandem with a criminal justice system that continued to target people who used heroin, and who sold heroin, and commercial traffickers of heroin. The harm reduction model, however, proffers no exit strategy from drug use or indeed methadone, arguably as addictive as heroin, as there is no requirement to titrate it down and cease its use. Consequently, this means the prolonged and extensive continuation of methadone and illicit heroin use for many individuals. What the HIV/AIDS epidemic did achieve was to further ostracise and marginalise people who used heroin, which coincidentally, if unintentionally, led people who used drugs in rural areas to gravitate to urban centres in search of newly opened specialist drugs services offering harm reduction services, anonymity and also the opportunity to buy and sell illicit heroin (Cicero, et al. 2014; Elinson and Campo-Flores, 2013; Koebler, 2014). Rural drug recovery services were unavailable at that time, due to the lack of people seeking such services thus effectively galvanising inner-city urban areas as centres of heroin use.

In 2008 the Scottish Government, which has devolved power over Scotland's NHS from the U.K., consciously and politically uncoupled Scotland's drugs strategy from the U.K. Government's harm reduction strategy in an attempt to reverse rising drug use and associated drug related deaths that had been notable since the 1980s (Miller, et al. 2008; Steger and Roy, 2010). "*The Road to Recovery*" drugs strategy was published in 2008 and was set to preside over the following 10 years. It was a notable change to the incumbent harm reduction model, identifying and instituting abstinence focussed recovery and, for the first time, offering an exit strategy from "heroin addiction" ***and*** methadone use.

Crucially, although not dissimilar to the mental health *Rights, Relationships and Recovery* strategy of 2007, neither those people who used drugs nor their families were invited to contribute to the development of Scotland's new drugs strategy, nor were their opinions sought.

The *Rights, Relationships and Recovery* strategy, however, foregrounded and underpinned *The Road to Recovery* strategy as drug treatment services fall under the remit of NHS mental health services in Scotland. *The Road to Recovery* strategy considered all those people who used drugs in Scotland to be similar and applied it wholesale to Scotland's "drug-using" community, cascading it from central government to drug service professionals who worked face-to-face with people who used drugs throughout Scotland. Within *The Road to Recovery* strategy, the Scottish Government defined recovery as:

> "A process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society," (Scottish Government, 2008, p 23).

The Road to Recovery strategy (Scottish Government, 2008) highlights the vision of drug treatment services in Scotland to be based on three principles:

- Recovery should be made the explicit aim of all services providing treatment and rehabilitation for people with problem drug use.
- A range of appropriate treatment and rehabilitation services must be available at a local level. Since different people with different circumstances inevitably need different routes to recovery.
- Treatment services must integrate effectively with a wider range of generic services to fully address the needs of people with problem drug use, not just their addiction.

Within *The Road to Recovery: Action Plan*, key actions include promoting recovery, delivering the recovery model, preventing drug use, enforcement and identifying and supporting children affected by substance misusing families, as a means of targeting "problem drug use". "Problem drug use" is defined as people who are experiencing or causing social, psychological, physical, medical or legal problems because of their drug use and are likely to be in touch with drug treatment services, although many will not be. Of course, this applies to "problem drug use." The strategy makes one specific reference to "rurality" identifying "innovative approaches" will sometimes be needed in such areas.

The ontological move from harm reduction to include abstinence, "a drug-free life", was a major change by the new Scottish Government, both politically and strategically. It aligned its position philosophically with contemporary leaders in research within the recovery field such

as Best, et al. (2011), McKeganey (2011) and White (2007), who conceptualise recovery as a bio-psycho-social model, rather than for instance, as a disease or moral concept, but all the while being juxtaposed to mental health recovery despite remaining within the same contextual remit. Within the rest of the United Kingdom, the U.K. Government's recovery strategy was also under review and in 2010 the then Home Secretary Theresa May published the coalition (Conservatives and Liberal Democrats) strategy on recovery: *Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life*, (HM Government, 2010, p.18) which states:

> "Our ultimate goal is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition."

In a move similar to the Scottish Government's strategy on recovery, the U.K. Government changed from a harm reduction model to one that explored exit pathways from addiction in the form of abstinence. The Scottish Government's strategy was to maintain the role of harm reduction whilst promoting its new recovery goal as abstinence, a stance the U.K. Government aligned with. The U.K. Government framed recovery as "living a drug-free life", solicited by those people who used drugs actively seeking to recover. Both the U.K. and Scottish Governments cite a belief that people who use drugs want a drug-free life but do not provide empirical evidence to support their beliefs. Parsons (2012, p.4), however, noted, "The strategy also clearly identifies an evidence-based approach and highlights the role of the Advisory Council on the Misuse of Drugs as a key element in this process".

Scrutiny of the 2008 *The Road to Recovery* strategy, however, highlights that its evidence base is heavily weighted with government statistics and reports. Studies drawn from people who actively use heroin or from data obtained outside urban environments are notably, if surprisingly, absent. *The Road to Recovery* nevertheless implies drug use *is* problematic and people who use drugs, as stated previously, are impoverished, unemployed and a danger to themselves and others. Arguably this stance may be as a result of the limited number of studies exploring people who use heroin in Scotland, surprising given the enormous impact heroin has on Scottish society. The few that there are, principally emanate from urban arenas (McIntosh and McKeganey, 2001; Neale, 1998) despite large swathes of Scotland being rural. It may be that rurality is traditionally perceived as serene, slow, and rustic, the very antithesis of an

environment for people who use drugs. Statistics may reinforce this as the Scottish Government data on drug use are sourced and collated from drug agency referrals (hospitals and specialist services), police reports linked to drug-associated criminality and social enquiry reports that record opiate and benzodiazepine use. The highest concentrations of data are drawn from urban centres as these have the highest concentration of people who use drugs and subsequently, addiction resources. Putt and Delahunt (2006), argue, however, that national surveys, used in the formulation of Scottish drug strategies, are unsuitable for detecting drug misuse and drug-taking behaviours because they are statistically biased by these higher population areas, leaving rurality unrepresented.

1.2 Justification for this study.

Illicit drug use perpetuates society along with its associated risk and harm indicators, such as violence, health issues, criminality, overdose and, increasing death toll. Although drug use and related deaths remain statistically higher in urban areas, drug use and related deaths also permeate rurality (Cicero, et al. 2014; Elinson and Campo-Flores, 2013; Koebler, 2014; Monnat and Rigg, 2018 and Szott, 2018). Statistics indicate that opiate "addicts" constitute 1% of the Scottish population, with 20% (1 million people) in Scotland living in rural areas, this equates to 200,000 people. Research, however, does not represent people who use drugs such as heroin, their drug-taking careers, or recovery from rural settings. It does not relay their narratives or everyday challenges they face; it couches urban and rural drug using people as one homogenous group and fails to explore or consider any potential differences. Rural people who use drugs, in fact, may have quite different skill sets, experiences, needs, resources, and pressures regarding their drug use, drug-using careers and recovery. Equally, rural settings and communities may present unique opportunities and challenges for people who use drugs and their recovery pathways. The dearth of literature on rural drug use and a surfeit on urban drug use indicates that rural heroin use, and whatever meaning recovery has to people who use drugs within a rural setting is uncertain and biased toward urban-sourced people who do use drugs. The considerable research on drug use and recovery within sociology and other disciplines is dominated by and reflects data drawn from these urban drug studies often centred on people who are "recovered" or "in recovery." Drug-using trends in Scotland, in line with other countries such as the United States (U.S.), demonstrate an increase in rural drug use (Scottish Government, 2015; Gundy, 2006; Hay et al. 2005), suggesting specific drug-using issues within rural settings. There is a clear and obvious gap in the current corpus of knowledge relating to people who use heroin in rural settings, noted by its absence within the literature.

Contemporary research, therefore, is essential to identify and understand illicit drug use, its changes and trends and recovery, specifically within rural settings. This is necessary if a historically marginalised and often ostracised community is to be provided with a voice and their everyday practices and related recovery are to be explored and understood. Specific information from rural people who use heroin is crucial if service providers, strategists and policymakers are to understand their specific needs and challenges, promoting the development of clear indicators for rural drug services to target and evaluate.

The Road to Recovery strategy concluded in 2018, offering me a unique opportunity throughout that final year to study rural recipients and explore them and its impact and influence over the past decade of its application and tenure. Crucially, it presented a means of understanding what effect, if any, the addition of abstinence to the Scottish drugs recovery strategy has had on rural people who use heroin. Exploring their "everyday" lives and practices (discussed later) afforded me the opportunity to identify specific challenges or indeed opportunities they encounter. To develop an understanding of them, their drug use and what, if any, meaning recovery has for them while at the same time presenting their realities and world views to fellow researchers and strategists who formulate and apply policy.

1.3 Aims and research objectives.

The study aim is:

To explore and understand heroin use, and what recovery means to people who actively use heroin, within the rural setting of Dumfries and Galloway, within the context of the Scottish Drugs Policy; "*The Road to Recovery*" (2008-2018) (Scottish Government, 2008).

Research objectives I consider in connection to the aim are:

- To investigate how people who use heroin in rural areas acquire, administer, and fund their heroin use (chapter 6).
- To investigate the use of heroin in the context of "everyday life" in a rural setting (chapter 7).
- To explore what meaning recovery holds for people who use heroin in a rural setting (chapter 8).

I employed and applied an ethnographic approach to explore the lives of people who use heroin residing in rural Dumfries and Galloway. Over one calendar year, I engaged with over fifty people who actively used heroin (see appendix 1) throughout rural Dumfries and Galloway, employing nonparticipant observation, participant-observation, field notes and interviews to generate data from and about them and their everyday lives and practices. Approximately half of the regions people who used heroin were believed to engage with recovery services, and my study only represents this demographic. I also (unexpectedly), engaged with twenty healthcare recovery service providers from the region's Specialist Drug and Alcohol Services (SDAS) who provide recovery and treatment services for people who report substance use disorders in the region.

My findings provide a valuable and unique insight into unstudied realities, world views, thoughts and everyday lives and practices of people who actively use heroin in a rural setting. This unique insight presents new and independent knowledge and information providing fresh and alternative sociological perspectives to contemporary discourse on heroin use and its associated recovery. The findings gathered have, amongst other points, identified how *The Road to Recovery* Scottish strategy, with its novel inclusion of abstinence as recovery, impacted and influenced the everyday lives, heroin use, and recovery of those people who used heroin within a rural setting. The resulting unique and original findings go some way to redress the current urban perspectives of people who use heroin and their recovery pathways.

Findings reject normative assumptions about people who use heroin and challenge many stereotypes, perceptions and literature about people who use heroin while providing crucial insight and information on their everyday lives and recovery. People who actively use heroin in rural Dumfries and Galloway were found to be well integrated, included, and accepted within their communities. Heroin use was not problematised with regulated and controlled heroin use commonplace and normalised despite individuals having access to both heroin and funds to purchase more even in the most rural areas. People who used heroin strongly rejected a deviant existential identity ("addict" or "junkie"), self-identifying as "drug users", but mostly as partners, parents, friends and employees. In general, there was an absence of everyday behaviours commonly associated with people who use drugs. For instance, violence was disapproved of, theft unusual, "shooting galleries" and rough sleeping were not present and public heroin use was abhorred. There were reports of violence, overdose and drug related deaths, but I did not observe these only physical health issues such as a leg ulcer, deep vein

thrombosis and blood borne viruses (HIV and Hepatitis C). Findings also reflect fundamental changes in behaviours associated with heroin use. For instance, heroin use was in decline, people who used heroin were older and where they once adhered to using heroin exclusively all now engaged in polysubstance misuse and alcohol use, potential factors underpinning the rise in drug-related deaths within the region. People who used heroin were in the main found to be rich in "recovery and social capital" (explored in chapter 3) despite a lack of anonymity. Despite all the ongoing inherent risks commonly associated with heroin use, overdose, violence, severe health issues and risk of death, my participants led mainly conventional, mundane but happy, fulfilling lives. Recovery in the form of abstinence as detailed by *The Road to Recovery* strategy was neither considered nor sought, despite recovery services being routinely accessed for methadone and other resources. Nor did the local recovery service (SDAS, provided free by the NHS) insist on or reinforce abstinence despite being affiliated with *The Road to Recovery* strategy. The SDAS primary focus was keeping their clientele "alive". Finally, findings identified significant gender disparity in favour of men, to the exclusion of women, specifically, women with children, within the region's population of people who used heroin and accessed recovery services.

1.4 Outline of the study.

Chapter one has introduced the rationale for the study, laying out the aim and research objectives. *Chapter two* provides a brief overview of dominant sociological discourse and competing concepts relating to addiction concerning drug use. Addiction as a paradigm has a long and rich history of scholarly attention across many competing disciplines. I provide a brief overview to locate and explain what people who use drugs in my study are considered to have and be "recovering" from. This chapter outlines the challenges in conceptualising addiction and its application to people as I determine how I operationalised "addiction."

Chapter three critically examines previous research and literature concerning recovery from drug use, while identifying key sociological concepts used to conceptualise it. In this chapter, I endeavour to explore, situate, and operationalise recovery in the context of drug use. While *The Road to Recovery* emphasises abstinence as the primary path to recovery and the SDAS implements harm reduction strategies, both of which I will acknowledge, I focus on three predominant sociological concepts, "identity, recovery capital, and everyday practices", to frame and contextualise recovery. I use these concepts as a framework to investigate and extrapolate recovery experiences from my participants and their lived realities. This

exploration involves delving into ontological politics and epistemological positions, considering the multitude of influences, both conscious and subconscious, and any resulting agency. It is through this lens, I consider an alternative perspective on recovery, one that interconnects these concepts and emphasises the notion of "change."

Chapter four explores and presents space and place in relation to rurality, and as a means of providing key sociological structure and construct to the geographical area of my study. Rurality is essential to my thesis aim and I examine prominent literature and analysis by sociological scholars linking rural substance use disorder as I search for potential determinant factors that explain the role that spatiality plays in drug use and recovery. I also explore what separates rurality from urbanity, investigating the requisites which constitute rural, and the political, economic, and social challenges, influences, and opportunities it presents.

Chapter five ends the literature review and examines the study methodology, identifying the conceptual framework and method I used along with data collection and analysis methods I employed. I explain the application and rationale of my chosen method and detail the participants and their recruitment process and associated ethical considerations. All participants are presented via pseudonyms and their information is collected through written records and presented in the Scots vernacular (for an English translation of Scot's, see appendix 2).

In *chapters six, seven and eight,* I present my participants and dedicate these chapters to the analysis of my gathered data from the field. Chapter six introduces my participant's drug-consuming activities and their setting concerning their heroin use and recovery. Chapter seven presents a vignette of two key participants' (in a relationship) "everyday lives" as they engage with a seemingly mundane task of attending a hospital appointment and the unseen challenges this presents. Chapter eight examines findings from key participants and recovery workers from SDAS, providing an illuminating insight into drug use and recovery from their binary perspectives.

Finally, in *Chapter Nine*, I offer a comprehensive discussion, focusing on my key findings and conclusions. I bring together my final thoughts, accompanied by an exploration of future research potential. This chapter serves as a platform to elucidate the substantial contribution to

research made by participants who share their experiences and realities of heroin use and recovery in a rural setting.

1.5 Definitions of key terminology.

I will explain and define the dominant terminology used throughout this study, starting with the term "recovery." I use the term in relation to drug use (primarily heroin), although the term will also be used in relation to mental ill health, and I will occasionally refer to that use as a means of contrast and comparison. "Recovery" is a label that has a rich tradition within sociology, which I rigorously and robustly explore in chapter three. It is, however, routinely applied by a multitude of disciplines and individuals within a variety of contexts both within and outside the sociological field, which I will occasionally include as a contrast. The term recovery equates to "abstinence" as identified within *The Road to Recovery* strategy and when referring to it throughout my thesis I specifically refer to recovery from drug use in this context when discussing it with participants. My understanding and meaning of recovery, however, goes beyond abstinence and harm reduction, and I consider and include other perspectives, at the same time developing my own perspective from medical to social as I realised the limitations of the bio-psycho-social, disease and moral models and the potential of a social model.

Rurality is another concept that has a long tradition associated with sociology and I explore this in chapter four. I apply the term "rural" to my study area, the "region of Dumfries and Galloway" (see appendix 3). I sometimes prefix Dumfries and Galloway with the word rural, as the region is intermittently referred to as "rural Dumfries and Galloway" in Scotland. I use Glasgow, the largest (and closest) Scottish urban centre, to occasionally compare and contrast my rural study area throughout my thesis, but I am mindful that this is not a comparative study.

Heroin refers to illicit "street heroin" and may be referred to as "gear" in this study. It is a class "A" drug (see appendix 4) in the U.K., within my study area it routinely consisted of up to 90% of unknown "cutting" agents (i.e., sodium benzocaine or baby milk formula), which was reported from tests conducted by the SDAS. Heroin sells in either .01g or .04g packets or "wraps", costing either £10 for the former or £20 for the latter. I extend and interchange the term "drug use" to encompass heroin use. This term also extends to other routinely used drugs such as illicit (street) benzodiazepines, cannabis, and prescription medication (i.e., methadone); their use was something I had not considered prior to my fieldwork.

Finally, the SDAS is the central hub that provides free nursing and medical recovery services to heroin “addicts” throughout the rural region of Dumfries and Galloway. It is part (funded and overseen) of the National Health Service (NHS) and the only service to provide substitute prescription medication such as methadone in Dumfries and Galloway. The purpose of the SDAS was initially to serve as a “gateway” for me to access people who used heroin, from which “snowball sampling” would take precedence but for reasons I explain within my thesis, snowball sampling never materialised. The greater majority of SDAS clinical staff are registered Mental Health Nurses (which should be assumed unless identified otherwise) who unexpectedly provided me with information and insight from a clinical perspective. Participants often refer to the “new SDAS building” by the service’s old building name “Cameron Hoose” (House).

Waiting for hours on a bus (any bus) out west. Summer 2018.

Chapter 2: Addiction

2.1 Introduction.

My thesis explores heroin use, people who use heroin and other drugs and what meaning recovery has to them in Dumfries and Galloway. Concepts of addiction have historically and routinely been used by various disciplines including sociology, alongside concepts of recovery. In this chapter, to preface the next chapter on recovery, I explore varied concepts of addiction that are discussed within the remit of sociology and wider disciplines. Addiction is routinely portrayed and applied negatively and pejoratively to illicit drug use. Therefore, in this next section, I describe how "addiction" has been constructed, and understood, exploring prominent models of addiction, and how the term may be reconsidered, operationalised and its application when in the field.

2.2 Understanding addiction.

Wanigaratne (2006) cited 98 different theories and models of addiction in 2001, although this list was not exhaustive. Defining addiction, then, is complex because it has been studied from various perspectives by different disciplines including sociology resulting in a myriad of interrelated and sometimes contrasting concepts and perspectives. Sussman and Sussman (2011), however, write that defining addiction is important to provide a testable and empirical base required for research into drug use.

Historically, the word "addiction" originates from the Latin "adiectio" used in Roman legal parlance as a formal award of a debtor to his creditor of belongings and objects, e.g., property, money, livestock and even people. Given that drug and alcohol use and misuse can be traced back over 4,000 years in human culture, the application of "addiction" being used as a label is surprisingly fragmented and new. Addiction, applied as a term for the misuse of, or dependence on psychoactive substances, is a relatively contemporary concept dating to the late 19th century (Goodman, 1995: Berridge and Edwards, 1987). Rosenthal and Faris (2019) propose the term was most probably drawn from and used by the popular press of the time who commonly cited discussion by and between prominent physicians of the day. Rosenthal and Faris (2019, p.439) assign the "modern medical conception of addiction to the work of Rush and Trotter" in the early 19th century, with Berridge and Mars (2004) suggesting the medical conception of addiction by the medical fraternity gave them "ownership" (which they arguably continue to

hold) bringing addiction into the public health domain. Singer (2011, p.1747) also suggests that the conceptual development of addiction is:

> "Linked historically to the emergence of global capitalism and its desire for labor control, (including their potential as passive laborers) and addiction being used commonly to label possibly unruly and resistant sectors within dominant colonial societies."

The 1926 Rolleston Report formally defined drug addiction as an "illness", assigning it a medical responsibility (Berridge, 1980), a decision that would have long-lasting societal consequences. Alcohol addiction in the U.S. was instrumental in highlighting addiction as a societal issue, simultaneously problematising it and bringing it to public attention. This position also came to be within U.K. society. In contrast to the highlighted "problematic" and widespread use of alcohol within the U.S., (alcohol in the U.K. was sold under licence from 1914 although forms of alcohol licencing are noted from the mid-18th century onward) it was drug use, in particular opiates, not alcohol, that was associated with the development of addiction and recovery.

Addiction has been studied widely within the disciplines of medicine, psychology, and sociology with each researching it in ways that meet their specific world views and requirements, leading to contrasting, and at times opposing discourse. Despite its dominance of the field of addiction over the past century, medicine has been unsuccessful in its attempts to develop a scientific basis for an addiction diagnosis because there is no one definitive test such as a blood test or rating scale (often applied within the mental health field for diagnostic purposes) that conclusively diagnoses or accurately measures addiction or how quickly or how much an individual becomes or is addicted. Neither is there a pathogen or gene that is linked to the causation or spread of addiction and disease which unlike addiction, cannot be voluntarily stopped at any point by the host. Addiction then is "diagnosed" from an individual's presenting signs and symptomology which are either interpreted by "an expert" medic (e.g., psychiatrist or psychologist) or through self-reporting and self-diagnosis. This predicates a long history based on medical/biological/psychological/disease concepts of addiction arguably to the exclusion of social, cultural, or environmental influences (see MacGregor and Thom, 2012; Scherbaum and Speka, 2008; Zimmering et al. 1951).

Sociologists such as Weinberg (2011, p.300) wrote when exploring addiction that:

> "…only a small fraction of studies actually speak explicitly to the nature of addiction itself. Furthermore, those studies that do broach the nature of addiction tend to render it somewhat counterintuitively and/or in ways that do not jibe well with much of the available empirical evidence."

In many ways, this reflects a discordant discourse amongst scholars as to the fundamental nature of addiction. Sociologists who do define addiction such as Bruce (2001, p.1) state that addiction is "excessive drug use". Zobenica (2019, p.234) considers it "a condition of periodic or chronic intoxication caused by repeated drug use" and Wilbank (1989, p.413) that it encompasses "those who believe that they have lost control of their drug use". Such definitions are open to interpretation and can easily buckle under robust scrutiny, a criticism also levelled at definitions proffered by other disciplines and researchers. Nevertheless, as identified earlier, there are a plethora of concepts which describe the nature of addiction, and I explore several prominent sociological and other concepts within this next section as I seek to understand the term addiction and identify a working definition.

2.3 Prominent models of addiction.

Concepts are human constructs created to explicate human behaviours. They retain validity until the generation of new data or changes in academic fashion renders them obsolete in the process providing vacuums for new ones to fill (Wilbank, 1989). So too with concepts of addiction. Sociological research has drawn on a wide variety of paradigms of addiction such as the individual (i.e., moral, medical and personality models), social relations (i.e., social and behavioural models), or the actual substance (i.e., pharmaceutical model). The multitude and diversity of addiction models not only highlight the complexity of this phenomenon but also highlights the array of perspectives from various disciplines attempting to understand it. These models offer different frameworks that elucidate and approach addiction, giving emphasis to factors such as biological, psychological, social, or environmental influences. In this next section, I explore some of those dominant models of addiction as a means of foregrounding their impact and influence as I attempt to operationalise it.

2.2.1 The "moral model" is based upon concerns relating to pervasive "immoral behaviour" linked to insobriety from the mid-19th century. Weinberg (2000) wrote that in the eyes of those

concerned, albeit lacking scientific rigour or empirical research, the immorality of addiction is driven by a person's asocial pathological desires, which leads to inherent moral weakness whilst simultaneously invoking moral censure by society. With regards to the application of the moral model, the individual would ideally return to societal acceptance when they develop "willpower" and consequently change their deviant behaviour/s so that moral fortitude returns (Earp, et al., 2019). Societal pressure to conform is thereby exerted and sustained. The moral model perpetuates in contemporary society where the label of addiction continues to be applied negatively and pejoratively even towards those who do not use illicit drugs, calling into question (and challenging) their morals and values of people for being pro-drug use. Erikson (1964) asserts it is not an individual who determines deviant behaviour, but their "social audience" who not only determine deviant behaviour, but also to what degree deviance is apportioned. Thus Szasz (1972), drawn on by Singer (2012), speculated that addiction, being neither a physical nor mental illness, is a social stereotype applied to deviant acts by "normal" people or conversely by "deviant" people to normal acts.

Becker (1963) also defined the concept of deviance as a social creation. Social groups construct deviance (and deviants) by creating and applying rules and boundaries within their society. Deviants are labelled "outsiders" as a result; their sole purpose thereafter is to conform and return to a non-deviant society, which relentlessly influences and cajoles them into doing so. The moral model perpetuates in contemporary society because it dovetails with and is reinforced by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) 12-step programme. AA and NA extol abstinence in tandem with a virtuous lifestyle, the polar opposite of what is considered the immoral lifestyles and behaviours often associated with people who have a substance use disorder.

2.2.2 The "medical model" has attempted to construct and diagnose addiction as a disease, with a great deal of sociological writing about addiction standing in defiance of this construct. Fundamentally, the medical model historically and contemporarily facilitates treatment for the "disease" of addiction, where once punitive action would have been invoked for "moral failings". The move from moral failure to medical disease was welcomed by "addicts" and their families because it shifted responsibility and accountability from the person's morals and associated behaviour to their "sick bodies". Addiction, however, is pathogen-free but Scully (2004) argues it can be a disorder of a structure or function, particularly where this produces specific symptoms or affects a specific bodily location in common with other diseases.

Fingarette (1988) on the contrary, concludes that addiction as a disease is embodied in four "scientifically baseless propositions" and the anomaly is clear: the disease model does not stand up to scientific rigour or scrutiny. He does concede though that its application does function as a catalyst for recovery. Trimpey (1996) agrees, stating that the concept of addiction to chemicals as "disease-based" is little more than a "useless theory", which cannot be supported scientifically. He suggests that if someone has the *disease* of alcoholism, this implies they are incapable of choosing to become independently "un-addicted", i.e., one cannot choose to relieve oneself of illness, such as cancer. Yet people routinely report "natural recovery" (free from medical assistance or prescription drugs) from drug and alcohol addiction. Although Ducci and Goldman (2012, p.2) note a "relevance of genetic factors in the development of addictions" these, they argue, are not singular causative factors. McMurran (1994) theorises that the application of the medical model cites "immoral problems", such as addiction within a physical framework, where physical issues cannot be located, and mental illness is therefore substituted. One last point worthy of note is that no other "disease" is criminalised.

Fenichel (1945), Gerard and Kornetsky (1955), Nyswander (1956), Laskowitz and Einstein (1965), Messinger and Zitrin (1965), Sington (1966) and Gilbert and Lombardi (1967) supported the premise of mental illness as a rationale for addiction, often founded within the context of "schizophrenia", which at that time was understood to be a case of "dual personalities". Depression, trauma (PTSD), low esteem and morale are also associated with prodromal effects of addiction, with drug use offering respite or a brief intermission from the pain of life and mental ill-health. Individuals with mental ill-health and those with chronic physical ill-health are known to commonly self-medicate, often with alcohol and illicit drugs, which may relieve symptoms but can also lead to addiction (Leeies, et al. 2010). However, Karpman (1948), Szasz (1961), Freedman and Wilson (1964), Dole and Nyswander (1967) and Pittel (1971), all refute mental illness as a *cause* of addiction, identifying most people with a drug use disorder as having no signs or symptoms of mental ill-health, a valid point to date.

The medical model of addiction retains a prominent position on the global stage due to the dominant role medical doctors maintain in forming and applying its diagnosis and treatment. In addition, their opinions are supported by influential, if arguably self-justifying, global medical texts. Contemporarily, prominent medical texts exerting influence on the application and understanding of addiction include the World Health Organization's "International Statistical Classification of Diseases and Related Health Problems tenth revision" (I.C.D. 10)

(2015) and the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorder", fifth edition (DSM V) (2013). Their criteria, whilst ambiguous, continue to be applied to people with a potential substance use disorder by healthcare professionals who then determine whether they fall within addiction remit parameters. The I.C.D. 10 (2015, p.4) defines addiction as a "cluster of physiological, behavioural and cognitive phenomena" characterised by the high priority given to the behaviours of appropriating and using "drugs"; behaviours which were once more socially and recreationally acceptable. In the case of drug use, this is underpinned by the overwhelming desire to take and use psychoactive substances to a point where tolerance is reached and surpassed as dependence is realised. Drug use is then continued and increased to prevent withdrawal symptoms and maintain the effects of the drug within the mind and on the body. The American Psychiatric Association which, has published the foremost psychiatric diagnostic text in North America, defines addiction as "a maladaptive pattern of substance use resulting in negative physical, social, interpersonal or legal consequences this does not include tolerance, withdrawal or a pattern of compulsive or uncontrolled use" (DSM V. 2013, p.227). The prominence of these texts can be understood when we understand that the application of a "diagnosis", or a "label" of addiction has historically been reserved and (perhaps surprisingly) given deference to the medical fraternity. Within a medical "diagnosis", addiction is set in the context of problematised drug use, and the numerous negative behaviours associated with it, where only abstinence equates to a cure.

2.2.3 The "personality model" emphasises people who have a substance use disorder as having "deviant personalities" with associated inherent drug using traits and behaviours. People who use drugs are seen to use and rely on drugs to resolve psychological problems, thus addiction is in part, a maladaptive coping strategy because, as Maris (1971) speculates, addiction is a coping mechanism against the vagaries of life brought about by a myriad of personal inadequacies. Biernacki, (1986), Chein (1966), Korntesky (1954) and Sharroff, (1969) theorised that addiction was due to poor self-esteem and a pessimistic outlook on life. Both Glatt (1968) and Weisman (1972) disagree, arguing that there is no type or form of addictive personality, principally because there is no evidence to substantiate such a theory exists. Klee (1970) also points out that it is difficult to make any clear distinction regarding pre-existing personality issues and addiction as there is no evaluation tool to assess people before and after they become "addicts". The term "addictive personality" however, continues to pervade society and transcends psychoactive substances and behaviours considered to be addictive.

2.2.4 The "social model" sets addiction in a social context, with Merton (1969) arguing social instability or "anomie" is the underlying cause of addiction. Merton theorised that those discrepancies and the imbalance between social and cultural goals in people's lives, (cultural goals being success and status, social goals being controls and means of attainment), lead to addiction. Raymond (1973) suggests the cause of addiction as being poverty of hope and finances, with Robin (1980), Heller, et al. (1987) and Singer (2012) adding prominent levels of socio-economic deprivation, unemployment and overcrowding as common social denominators for drug use and subsequent addiction. Lukoff (1973) also notes that "addicts" are automatically socialised into deviant activities when they experiment with drug use. West (2006) acknowledges that addiction is then reinforced by social pressures such as role modelling and peer pressure. Society reinforces deviant behaviours because people who do not use drugs and the criminal justice services reject, criminalise and ostracise people who use drugs and their associated drug using behaviours. Of course, this model does not stand up well to scrutiny when applied to people who are wealthy, socially assertive and successful. They are positioned with resources and support to meet their goals and are free from the common denominators cited as causal by the social model of addiction (poverty, unemployment, overcrowding) yet they too can develop substance use disorders (Merton 1969; Luthar, et al. 2013). They are, however, rarely if ever, marginalised or ostracised by society because of their privileged positions and status, which can also extricate them from the criminal justice system.

2.2.5 The "behavioural model" sets addiction as a learned behaviour. Wikler (1965) and Vaillant (1969) theorised and propound addiction as being caused by learned behaviour, a position supported by Salmon and Salmon (1977). They also suggest if addiction is a learned behaviour, then like all behaviours, it too can be unlearned. Wanigaratne (2006) agrees addiction is part of operant and classical conditioning, either reinforcing or stimulating behaviour, which then leads to and maintains addictive behaviours. This would again indicate a propensity for the addictive behaviour to be unlearned. People who are "addicted" to drugs, therefore, in theory, could be behaviourally modified out of addiction, something which has not yet been successfully mastered.

2.2.6 The "pharmaceutical model" links addiction with the chemical composition of drugs. Dole and Nyswander (1967, p.22) write that heroin addiction is the result of the "imbibed drug rather than a psycho-genetic rationale". They theorised pharmaceutical effects of heroin lead to "drug-hungry addicts" whilst the use of methadone blocks heroin cravings, allowing people

who use heroin to cease their heroin use and return to being "worthy" members of society. Amongst contemporary evidence, Bourgois (2000), Neale (1998) and Nguyen, et al. (2019) for example note that methadone is potentially if not more addictive in its properties than illicit heroin. Rassool (1998) agrees that addiction may be caused by drugs stimulating the reward centres of the brain with the reward diminishing as the drug is continually used and tolerance experienced, hence leading to the need for increased amounts to achieve past effects. Drug use is also routinely complicated by the biological and physical effects of withdrawal, driving those who use drugs to use more in a bid to stave off withdrawal effects whilst reinforcing the "addictive" process of the pharmaceutical chemicals. West (2006) and AA, (2018), also give credence to addiction following drug use, thus supporting a chemical-based link to the cause of addiction. Alexander (2001), however, queries if drugs are the cause of addiction, posing the perennial question, why is it that some people can use alcohol and other drugs over their lifetime and never develop a substance use disorder? Orford (2001) and Reinarman (2005) support Alexander (2001), positing that people who use psychoactive substances do not automatically become "addicted" (opioid-based analgesics in childbirth for instance), even where excessive and prolonged use are noted. Sporadic addiction, therefore, indicates that the chemical effects of drugs are experienced in different ways, alluding to the probability that the drugs themselves are not the cause of addiction. Nor is there an accepted measure of how addictive a drug is, other than through the demand of the people who use drugs or by third parties stating certain drugs such as heroin, are highly addictive. As with the previous models, the potential for pharmaceutical elements within a drug being a causative factor in addiction holds sway in sections of society because it cannot be discounted.

These models offer a limited representation of the complex and intricate nature of addiction, providing a brief insight into the diverse perspectives from various disciplines. They reflect an evolving scientific understanding which informs treatment and intervention approaches designed to mitigate risk associated with addiction or support pathways to recovery. Despite this diversity and plethora of associated literature, a consensus on the causes of addiction or its precise nature has yet to be reached.

2.4 Addiction reconsidered.

With so many concepts relating to addiction, authors such as Peele (1985) and Campbell (2007) suggest such theories do little more than recycle conjectures that lack any scientific basis in empirical facts. Models, however, still hold credence within differing and

competing disciplines, but as West (2006) asserts trying to find one specific cause of addiction is a pointless and futile endeavour. Perhaps Hamersley and Reid (2002), who cite academics such as Szasz (1974), Peele, (1985) Fingarette, (1988), Davies, (1993) along with other academics such as Davis (1997), Peele (2001), Hammersley and Reid, (2002), Reinarman (2005), and Weinberg, (2000; 2011) are correct in citing addiction is nought but a "myth".

Reith (2004) extends this perspective further, challenging mainstream thinking by positing that "addiction" could be considered a lifestyle choice, enacted by the free will of the "addict". Reith proposes that the freedom to use drugs should be universally accepted, and society should refrain from intervening. Drug use, Reith posits, should be considered a basic human right, and thus addiction (and associated criminality) could be dismissed as a concept. Reith (2004) points out that labelling is driven by agendas of prohibition and control aimed at shaping individuals and social groups. This perspective critically conceptualises consumers, shaping their actions and behaviours to align with societal needs dictated by authoritative governments. The perceived loss of control undermines personal agency, freedom, autonomy and choice and contends that addiction, framed as loss of control, extends beyond substances to encompass a wider range of commodities and experiences. Addiction, then, arguably introduces tensions within the context of neoliberal values ingrained in western society, where the freedom to choose is a central tenet, but adherence to cultural norms, as dictated by social institutions, is simultaneously expected to maintain personal liberty.

Orford (2001) and Foxcroft (2008, p.139) dispute such perspectives, writing that although addiction may not have a single cause, it remains a real entity, affects countless lives and often leads to untold suffering and death. Foxcroft goes on to explain that addiction can affect anyone, surmising that addiction is "a constant and perhaps natural state." Orford (2001), however, accepts many people use licit and illicit drugs and most, the vast majority, in fact, do so without becoming "addicted". He theorises that this is because addiction is an individual idiosyncrasy. Peele (1989), in contrast, writes that a diagnosis of addiction does nothing more than provide legitimate excuses for deviant actions, considered socially unacceptable when alcohol or drugs are not a factor (for example, criminality, violence, promiscuity).

Juxtaposed to such perspectives, and key to my study is Weinberg's (2002, p.16) position on addiction whereby he rejects the premise of an "addict as innately impulsive, hedonistic, short-sighted, undisciplined, self-centered and incapable of deferring gratification" and challenges

the assertion of the power substances reputably hold over people's wills, leading to the need for regulation by governments to protect its citizens from addiction. Weinberg (2022, p.2) highlights the essence of addiction is at "odds with the paternalistic ethos found in most mainstream medical sciences." He, as with Berridge (2013), Orford (2001) and Zinberg (1984) argues that "the vast majority of drug users do not become addicted" (Weinberg, 2011, p.307) because addiction is subject to sociological dimensions. If, as he argues, that disease is considered from a post-humanist perspective as "harmful bodily articulation", then he admits addiction *may* then be an entity. Of course, if Zinberg's (1984), Oxford's (2001) and Weinberg's (2011) assertions are correct that not all "users" of opiates become "addicts" (and one must also consider the routine use of prescription opiates in the millions of "patients" globally here for analgesic purposes for instance) it has the potential to impact on the meaning of recovery within the context of people who use heroin but who do not problematise their drug use. What recovery might mean, if it is considered at all, to those who use illicit opiates but are not self-reporting "addicts" is uncertain.

While self-reporting may frame an individual's identity as an "addict," expert medical opinion confirms it, although they continue to seek causation and epidemiology for validation. The term "addiction" is now, however, synonymous with problematic behaviour and spoiled identities, depicting "addicts" as almost mythical figures in need of forcible intervention and "cure", attributed to their perceived inability to resist heroin regardless of consequences as they fail in their ability to monitor and maintain their freedom. Conversely, sobriety, while seemingly ideal in societal norms is fixed and unchanging and arguably sits juxtaposed to neoliberal ideals of dynamic freedom and individual choice. Curiously, however, addiction, as noted previously, continues to lack empirical grounding or any definitive measure; it eludes empirical testing and evaluation rendering it an enigmatic phenomenon that transcends conventional understanding and application, while retaining the power to influence identities in ways that are mostly negative, unwarranted and unhelpful by society, nonetheless the label is liberally applied.

Davies (1993) asserts that people self-administer drugs based on their own volition and self-will, which are inherently influenced by their immediate and available choices, that are both fluid and unique to everyone at the time of their drug use. According to Davies, people who use drugs maintain control and power over their actions, even during drug use, rejecting the notion addiction is primarily driven by factors such as pharmacological factors. For some, the

label of addiction serves as a catalyst to overcome their dependence although addictions' purely subjective nature often leads to objectification by external perceptions. For others, a label of addiction present opportunities, such as access to state benefits, free methadone, housing assistance and an exemption from having to work, highlighting a clear link to "negative recovery capital". Addiction, however, may merely countenance risk, which could be mitigated through alternative approaches such as pharmaceutical-grade morphine or supervised consumption facilities.

Singer's (2012, p.1747) anthropological monograph on addiction crucially reports on ethnographical studies of the "everyday" of people who use drugs. He found people who use drugs cite their self-identities as positive, with "cultural order and socially constructed purpose and meaning" leading to aspects of addiction being "affirmative, creative and sustainable", not the problematised lifestyle portrayed by politicians, people who do not use drugs or the media (Manning, 2007), what Weinberg (2002) refers to as "victim-blaming". Singer (2012, p.1752) explains the need for further ethnographic studies to explore the "drug-using world" to provide a "user's perception of drugs risks and benefits" and thus ensure equity and balance within the discourse and literature. The complexity of addiction is well-documented, encompassing both a physical and psychological drive to pursue "rewarding" stimuli, irrespective of the often known and dangerous consequences to an individual's life. Scientific communities are known to recognise addiction as a genuine and treatable condition, and they continue to work to develop evidence-based interventions and strategies for prevention and treatment. However, the root cause of addiction is not solely attributed to physical and psychological factors; rather, it is shaped, identified, and influenced by societies and cultures. The label of "addict" although often applied pejoratively, can result in varied treatments and interventions for individuals, mostly contingent on their circumstances and environment.

2.5 Chapter conclusion.

Much of the history of social policy concerning psychoactive drugs has been predicated, at least ostensibly, on the claim that illicit substances possess unusual powers over people and must be regulated (prohibited, criminalised, legislated) to protect citizens from their own personal proclivities to succumb to their addictive use. Quite why a substance is addictive, or why a person develops a substance use disorder, remains unclear. What has become clear is that there is no single model which sufficiently explains addiction's multifaceted nature, which has left the condition contested, immeasurable and arguably, undiagnosable. Dominant lines of

arguments do, however, accept that addiction is multifactorial and lacks one specific causal element. The label of addiction may be considered among a myriad of categories, such as a fetish, a punishment or mechanism of social control imposed on a supposedly weak-willed working-class (Marx, 1979; Davies, 1993; Reith, 2004 and Weinberg, 2002). This has led to its many concepts, world views and oppositional discourses that do little more than strengthen opposing perspectives which are so broad as to become unhelpful and create ongoing interdisciplinary tensions. While some people who use heroin may acknowledge their addiction, some do not, and it is important to understand that dependency can extend to anything but does not automatically result in a loss of self-control or chaotic lifestyle.

In my capacity as a registered nurse, my training and nursing responsibilities are underpinned by the framework of the medical model of addiction, which I routinely advocated. While this fundamental ontology shaped, governed and influenced my perspectives, the nature of addiction is clearly not limited to one single perspective and it is essential to consider viewpoints offered by other disciplines, such as social sciences. Upon closer examination, I find alignment with scholars such as Becker (1964), Peele (1985), Davies (1993), Bourgois (1995), Weinberg (2002) and Reith (2004) who challenge traditional models of addiction and assert that the concept of addiction to be a social construct. The concept that addiction is moulded, specified and sustained by social, cultural and historic influences, rather than a reality that is either inherent or objective, forms the foundation what constitutes “addiction”, its identification and how people who are labelled “addict” are considered. Importantly, this understanding is not in fact static but varies dependent on the society and is subject to change over time. This perspective is rooted in and gains credence from insights shared by my participants in the forthcoming chapters.

My insights challenge prevailing discourse and common notions, contesting stereotypes that all people who use heroin are “addicted”. They contest the premise that heroin use, and addiction inevitably result in a loss of self-control, chaos, disorder and criminal behaviour. Instances of willpower and an innate ability of my participants to maintain their identities were evident. I observed them embody and navigating the social construct of addiction, often demonstrating control over behaviours associated with addiction to engage with "recovery" strategies and access necessary services such as methadone and benefits. Recognising that individuals can exhibit addiction as a "performed" behaviour, varying their “performance” across different contexts, challenges the idea that addiction is solely biological, psychological,

or pharmaceutical in nature, and which warrants medical intervention (Weinberg, 2022). In this next chapter, I will move on to consider the concept of recovery.

In search of rough sleepers who have experience of heroin use in Dumfries. Summer 2018.

Chapter 3: Recovery- How the term recovery has come to be constructed.

3.1 Introduction.

In this chapter, I review historical and contemporary constructs of the term recovery within the context of drug (and alcohol) use, focusing where possible specifically on heroin use and people who use heroin in rural settings. I consider normative assumptions of recovery and Scotland's drugs recovery strategy, *The Road to Recovery* (2008-2018) (Scottish Government, 2008), which in my view constructs and foregrounds recovery as abstinence and is different from the harm reduction strategy of the rest of the U.K. due to Scotland's healthcare system being devolved and autonomous. I go on to discuss the limitations of the Scottish recovery strategy, set as it is, within the parameters of the U.K.'s dominant prohibition laws (Misuse of Drugs Act (1971)) and the resultant political tensions between Scottish and U.K. administrations. I also consider recovery in a wider context exploring what alternative recovery concepts there are to abstinence. I argue that the term recovery is widely used and appears to have a multitude of meanings, applications, and interpretations. These meanings are fluid, flexible and susceptible to extrinsic pressures on both actors and stakeholders to whom recovery is applied, or who claim agency within its sphere of influence and related treatment and recovery services. I explain that recovery is not easily conceptualised, defined, or articulated and goes beyond abstinence and to this end, I identify and appraise the term from three widely accepted sociological concepts: identity, recovery capital, and everyday life. I begin by examining the generation of recovery and its place and construct within the drug strategies of the U.K. and further afield.

3.2 The development of the concept of recovery.

The concept of recovery can be traced to the 18th century, where it manifested in various guises, for example, reformation, redemption or rehabilitation and was associated with dependence, intoxication or overuse of alcohol or drugs (White, 2005). The term was routinely associated with the kind of addiction that was formally conceptualised and categorised as a "chronic disease" in the 1920s (Kurtz and White, 2002; Mars, 2003; El-Guebaly, 2012; Witbrodt, et al. 2015). At this time, the U.K. registered nominal numbers of opiate (morphine and heroin) dependent people. For instance, in 1935 there were 700 registered opiate dependent people and in 1959, following the synthetisation of methadone at the end of World War II, there were 456, with 50-70 specifically identified as people who used heroin (Spear, 1969; Mold, 2007; Winship, 2014). The demographic profile of people who used heroin reflected

affluent men over the age of 35 years residing in London. Heroin use at that time was commonly associated with bohemian and artistic lifestyles or with medical practitioners. The categorisation of addiction as a disease may have served as a socially "acceptable" reason for opiate dependence. This afforded people who used opiates a semblance of respectability, enabling them to preserve their social standing and reputation within the U.K.'s strict class hierarchy.

As a disease, addiction was eligible for treatment, and people who used opiates were diagnosed as being "incurable addicts" by their doctors and were provided with prescriptions. They paid for and received pharmaceutically pure morphine as part of their treatment and care (Mars, 2003). Pharmaceutically pure morphine could be prescribed when those who used opiates were "registered" as "opiate addicts" where:

i. *Complete withdrawal produces serious symptoms which cannot be satisfactorily treated under the ordinary condition of private practice; or*
ii. *The patient, while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn.*

(Ministry of Health, 1926; Mars, 2003).

In line with other chronic physical diseases, however, there was an expectation made by the medical professions that, through self-management and with support, people who used opiates would actively seek and accept reducing doses of morphine. They would then return to "mainstream" society, preferably abstinent or maintained on a low-level pharmaceutical opiate that allowed them to return to their previous roles or perhaps a new one where opiate use could continue (Stimson and Oppenheimer, 1982; Mars, 2003). Recovery, framed in this context, could be considered as an attempt to reduce drug dependency whilst increasing social responsibility, but with medical support. The Rolleston Committee (1926, p.6) noted that "In this country (U.K.), addiction to morphine or heroin is rare" reflecting the need for minimal resources to implement and enable recovery which should be predominantly privately funded by the "addict" or their family.

The advent of the NHS in 1947, however, introduced "free medical care to all" within the U.K. and new "specialist health" services for illicit drug "treatment" were instigated in London. General practitioners and psychiatrists continued to prescribe (free of charge) injectable

pharmaceutical-grade morphine and methadone (a manufactured synthetic opioid) to people who used opiates as part of their treatment. Injectable methadone was phased out in the U.K. in the 1950s. Oral methadone was considered more socially acceptable and cost-effective than injectable opioids and as such was marketed as a vehicle for abstinence from the 1950s onward. Methadone was systematically prescribed to an escalating number of people who used opiates seeking medical assistance from the NHS, and consequently access to free pharmaceutical opiates until the early 1970s. The implementation of methadone was grounded in the "harm reduction model" which was recognised to mitigate negative social and physical consequences and risks associated with addiction, as identified in subsequent sections. The model's aim was to facilitate adherence to methadone of people who reported an opiate dependence (Best, et al. 2016a; Reuters and Stevens, 2007; Sporer 2003).

This model of recovery remained in place within the U.K. until the advent of the Misuse of Drugs Act (1971) which aligned British law with the United Nations Convention on Narcotics (1961). The U.N. convention was developed under the influence of and chiefly lobbied by the U.S. (a major financial donor to the U.N.) due to U.S. concerns about escalating drug use throughout western society (Bewley-Taylor, 2005; Jelsma, 2003). The Misuse of Drugs Act (1971) enabled the United Kingdom's judiciary to enforce prohibition and criminalise drugs, drug use, and those who used drugs which sat juxtaposed to the incumbent harm reduction model. The Misuse of Drugs Act (1971) led to a long-lasting tension between the criminal justice system which prohibits and criminalises illicit drugs and their use and recovery services which advocated harm reduction, which I consider in later sections.

The inception of the Misuse of Drugs Act (1971) was implemented upon a notably low numbers of registered people who used opiates characterised by an absence of political or societal concerns regarding opiate use and associated dependence. The scarcity and excessive cost of opiates restricted their use to the wealthy. Illicit opiate use, however, was becoming fashionable and popular, accompanied by its increased availability and affordability. This phenomenon was explained by London (2005, p.102) as a "youth subculture", who procured illicit drugs and shared their injecting paraphernalia, leading to increased use and dependence within a new social demographic. Opiate use in the U.K. has escalated from a modest 2,000 registered individuals in the 1970s to an estimated 200,000 in 2017 (Office for Health Improvements and Disparities, 2021; Public Health Scotland, 2021).

During the mid-20th century, in the U.S. the conceptualisation of "addiction" was similarly located in the disease model. The paradigm of "recovery", however, was associated with temperance movements, which advocated for abstinence as opposed to harm reduction. These temperance movements maintained a negative stance toward the alcohol industry, the unregulated use and sale of alcohol as well as "drinkers" themselves (Levine, 1978). According to Levine (1978) prior to the temperance movement, alcohol use and "drunkenness" were not problematised by society; rather, they were accepted and often embraced as part of U.S. culture. Contrarily, White (1998) asserts that those within the temperance movements played a pivotal role in attributing alcohol use and addiction with immorality and sin, with alcohol denigrated and placed as a catalyst for the foundations of familial breakdown and societal disintegration. In response to prevailing public sentiment and influenced by temperance movements, "support groups" such as the Washingtonians, (a group of "ex-alcoholics") were set up. These support groups provided sponsorship to "alcoholic" men actively "encouraging" them to take a "pledge of abstinence" (Blumberg, 1980, p.38). The Washingtonians, grounded in shared experiences of alcoholism, offered both empathy and support to help "drunkards", which Fletcher (2008) argues contrasted with the widely held societal doctrine of the time which generally stigmatised "alcoholics" as contemptuous, sinful, and immoral. By framing addiction as a "societal problem" these support groups became instrumental as early catalysts for societal and political change and the introduction of prohibition laws (i.e., National Prohibition Act 1920 or Volstead Act) of the 1920s and 30s (White, 1998; Fletcher, 2008; Herring, 2013).

As we have seen, both U.K. and U.S. legislatures prohibited illicit drugs and criminalised their use. In the U.S., influenced by Alcoholics Anonymous (AA) and sister organisations, abstinence was the primary model for recovery. Conversely, within the U.K., despite the popularity of AA and NA, statutory services adopted a more pragmatic approach. They prioritised maintenance treatments as a strategic approach enabling people with a substance use disorder to live with their addiction whilst remaining and functioning within society. Transparency constitutes a fundamental premise for recovery in the U.S. and as Nolan (2010, p.40) emphasises "Brits won't talk to each other in the free and easy, relaxed, and very open way that Americans will talk to each other," anonymity, however, is a key factor to AA. The subsequent sections explore the abstinence model of recovery, which forms the basis of U.S. policies, and the harm reduction model, which serves as a foundational framework for the U.K. approach.

3.3 The abstinence model of recovery.

The ultimate "failure" of prohibition and rejection of the temperance movement gave rise once more to support groups such as AA. AA developed a Christianity-based 12-step programme to abstinence using ex-alcoholics as sponsors, anonymity to lessen shame, and free support groups. AA are considered the founders of "recovery" as a legitimate concept, i.e., valid and accepted within and by society (Douglas, 1987; Alexandre and Laudet, 2007; White, 2007; Inanlou et al., 2020). Within AA, recovery is defined as members achieving and maintaining sobriety (Gross, 2010; Alcoholics Anonymous, 2020) within a central doctrine of "total abstinence" (Alcoholics Anonymous, 2020, p.18).

AA and its affiliates Narcotics and Gamblers Anonymous share a central core principle that only total abstinence can avoid the overwhelming grip, effects, and consequences that a (specific) drug has upon an individual. No amount, however small, can ever be imbibed lest a dormant "allergy" to alcohol or drugs reignites. Thus, members are never considered "recovered", even when abstinent. They remain in perpetual remission in a continual ongoing state of recovery, and it is only with help from a higher power that they remain abstinent. In the 1990s "New Recovery" paradigms were developed in the U.S. aligning addiction as a "chronic disorder" requiring ongoing long-term community-based treatment and support but also requiring people who use heroin to co-operate and demonstrate a level of willingness to engage with recovery (Sobell, 1992; White, 2000; Best, et al. 2016b; Winship, 2016).

The emphasis on abstinence and voluntarism aligns with the influential Betty Ford Institute Consensus Panel (2007, p.222). This panel sought to define the concept of recovery which is routinely cited by drug researchers due to its elevated profile and influential research into addiction and treatment (McLellan, 2010). The panel defined recovery as, "a voluntarily maintained lifestyle composed and characterized by sobriety, personal health, and citizenship." Similarly, the U.S. Department of Health Center for Substance Abuse Treatment (2020, p.9), a key contributor to American drugs policies and strategies, defines recovery as "a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life," locating better health with abstinence. Consistent with this perspective, other contributors to recovery research (e.g., Arndt and Taylor, 2007; Belleau et al. 2007; Galanter, 2007; Laudet and White, 2010) assert freedom from addiction achieved through abstinence as imperative to a recovery lifestyle.

The concept, however, faces critique from Nutt (2011), who argues that it is a binary evaluation measure, resulting in the individual being viewed as either a success or failure, thereby compromising their human rights, such as the right to freely access and use drugs, which is simultaneously removed. Although there is consensus in the U.S. for an abstinence-based model of recovery, recovery definitions are criticised for a lack of clarity and the difficulty in operationalising them. Laudet's (2007) study of inner-city drug use in the U.S. highlights this issue, as she found that because recovery was not "operationally defined" by addiction treatment and research communities, this has led to disparate recovery models lacking shared and standardised measures.

3.4 The harm reduction model of recovery.

In contrast to the U.S., the U.K. has traditionally conceptualised drug-associated recovery through a harm reduction model (Single, 1995; White, 1998, 2005; Fletcher, 2008; Noland, 2010; Valentine, 2011). Although U.K. policy has always implicitly implemented a harm reduction model, it rose to public prominence in the late 1980s following the HIV and AIDS epidemic. Buoyed by fear, a public outcry saw the U.K. government intervene to minimise the HIV/AIDS epidemic spreading through the needle-sharing opiate-injecting community and potentially into mainstream society through sexual contact (Keane, 2003). Stimson (1998) and Gilchrist et al. (2017) wrote that as drug addiction increased through the 1970s and 1980s, harm reduction techniques moved from individualised treatment to a risk-orientated large-scale public health application.

Harm reduction is operationalised to decrease problem drug use and associated risk caused by drug use; abstinence (in contrast to the abstinence-based recovery concepts espoused within the U.S.) was not considered a priority in recovery in the U.K. This model can be seen influencing the work of the U.K. Drug Policy Commission (2008, p.5), which defined recovery as a "voluntarily sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society." The ontological approach to recovery adopts the paradigm of "controlled use" of the drug and advocates "harm reduction" strategies for people who use drugs concurrently addressing wider societal implications. This approach accepts ongoing drug use, a philosophical stance that is diametrically opposed to AA's principles of abstinence and legislation enshrined in the U.K.'s Misuse of Drugs Act (1971). Consequently, harm reduction extends beyond individual drug use, adversely affecting trafficking, whilst concurrently diminishing the demand for drugs.

Harm reduction measures extend to free needle exchange, where used needles can be deposited for safe disposal in exchange for new sterile injecting equipment (referred to as "works" by my participants), health education and promotion, oral pharmaceutical alternatives (i.e., methadone) and risk orientation. Services are funded through the NHS and third sector organisations by the U.K. and Scottish Governments from taxes. Harm reduction proved successful in reducing HIV transmission within the IV drug-using population in the 1980s and 1990s. It also had a positive impact on other blood-borne virus (BBV) transmission (specifically hepatitis-C in the late 1990s) and arguably, reduced drug-associated criminality such as theft and violence (Davenport-Hines, 2001; Gilchrist, et al. 2017). More recently, harm-reduction approaches have been promoted in an attempt to stabilise drug-related deaths (caused by overdose).

Advocates for harm reduction such as Schiebe, et al. (2017) and Delargy, et al. (2019, p.1) argue that harm reduction policies provide stability within otherwise "chaotic" lives so "further improvements to support and treat patients can be made." Similarly, Keane (2003, p.227) found that supporters of harm reduction assert it as "a progressive, practical and self-evidently effective approach to drug use." Khorasheh, et al. (2019), Kilmer, et al. (2011) and Ritter and Cameron (2006), however, found the harm reduction model to have had a notional impact on reducing heroin use within the U.K. reflected by the high number of people registered as "opiate dependent" and an associated increase in drug-related deaths, particularly in Scotland.

Harm reduction approaches are recognised to foster agency and autonomy, challenging the notion that "dominant addiction interventions conceptualize the addict as powerless - either through moral or physical weakness" (Gowan, et al. 2012, p.1251). This not only influences the mitigation of harm caused by heroin use (overdose, health issues and death) but also benefits society, by reducing the often-associated criminality and violence. The harm reduction model is criticised by proponents of abstinence because it perpetuates drug use and is routinely criticised for "parking addicts" on methadone (potentially as addictive and more harmful than heroin) over prolonged periods without any apparent exit strategy (Bell, 2014; Duke, 2013; Keane, et al. 2003). Notably, there is no clear consensus for an exit strategy from drug use identified by supporters of the harm reduction model. *The Road to Recovery* strategy effectively addressed this concern by offering abstinence as a viable exit route from (harm reduction) recovery processes. The strategy, however, considers drug use and people who use

drugs pejoratively identifying them to be problematic, a danger to themselves and others and a drain on societal resources.

Neale, et al. (2011, p.192) similarly found that, through interviews with recovery service users in the U.K. that it was "not … possible to formulate a complete consensus around what recovery is." Instead, the concept of recovery involved people who use heroin and self-defined their recovery and journey, articulating what recovery meant to them, including its boundaries and significance. The notion of "being normal" featured prominently, although "normal" was hard to quantify, and notably abstinence was not a priority or primary goal within their self-defined concept of recovery. This supports empirical findings by Borkman, et al. (2016), Laudet (2007) and Neale (2011, p.1116) who reported that people who use heroin define recovery as "ways of being, a growth or learning process involving internal values and self-awareness with moral dimensions", a description at odds with many recovery-orientated policies and practices (Best, 2009; Granfield and Cloud, 2001; Laudet, 2007) which uncouples recovery from abstinence.

In summary, the term "recovery" exhibits multiple uses and applications in the context of various models. A seemingly ubiquitous and commonly applied label its application to those who use drugs proves multifaceted and elusive. While recovery remains tied to the dominant models of abstinence and harm reduction, it has evolved to encapsulate what people who use drugs wants it to be. Consequently, it often reflects their own ongoing challenges to address (or not) their own drug use (and addiction) which may or may not be influenced by recovery services, wider philosophies, and societal pressures. This conceptualisation identifies that recovery is both deeply personal to the individual and an ongoing process of change that rejects the application of external criteria. I now turn my discussion to consider three important concepts relevant to recovery within sociology: identity, recovery capital and the everyday.

3.5 Identity in Recovery.

The concept of an altered identity originates from Erving Goffman's exploration and comprehension of stigma (1963) where a "spoiled identity" is apportioned negatively to an individual, usually because of social marginalisation or deviant behaviour. Biernacki's (1986) seminal research, *Pathways from Heroin Addiction* drew on previous research (such as Goffman, 1963; Winick, 1962; Brunswick, 1978 and his previous work with Waldorf, Waldorf and Biernacki 1981), to explore the experience of one hundred in-treatment heroin dependent individuals in the U.S. using an ethnographic approach. Biernacki's ethnography explored the

assumption that recovered and recovering people who used heroin were reliant on professional assistance to recover. His interviews drew out in-depth information from their individual lived experiences to uphold or challenge the hypothesis. Biernacki (1986, p.127), explains that many people who use drugs only consider recovery when they no longer derive pleasure from drug use, any initial enjoyment having dissipated to be replaced with drug use that allows "normal daily functioning." This is underpinned by the need and drive to avoid withdrawal symptoms. Biernacki cites his participant's perception of their "identity" as being a common denominator and central to their recovery.

Biernacki's research challenged the then commonly held social belief that, before the 1980s, those who used heroin could only recover with help from "professionals" and "structured interventions" because addiction was incurable and chronic. Biernacki, however, noted "natural recovery" was prevalent amongst people who used heroin. In its most basic sense "natural recovery" means overcoming addiction without the involvement of professional services (Granfield and Cloud, 2001). The term "natural", however, faces challenges within a sociological framework, where phenomena are constructed. Murphy (1995, p.688) wrote that sociology is embellished in a "revulsion of biological determinism" and "natural recovery" in this context is without recourse to social construct that recovery services arguably provide. Waldorf and Biernacki (1979), however, contend that "natural recovery" is as effective for the treatment of addiction as professional services. Junge (2012) added that achieving successful recovery through "natural recovery" may take several attempts before an individual overcomes their addiction successfully due to a perceived lack of support from i.e. service providers. Of course, relapse also happens where professional services provide support.

Biernacki (1986) examined the "spoiled identity" of people who use drugs (an identity that leads to a person experiencing stigma), discussed by Goffman (1963), and how their "differing" identities manifest and conflict with one another because of their drug use and the impact and changes addiction has upon their identity, for instance as a parent, a friend, or an employee. Biernacki *constructs* addiction recovery as being dependent on recovering from a spoiled identity. Addiction and spoiled identity, Biernacki writes, are bound together, which means recovery is dependent upon challenging, changing and then managing one's identity, but importantly also *enables* a conceptual framework that allows for the process of "natural recovery" i.e., recovery without recourse to healthcare professionals. To maintain recovery

where an individual feels they have a spoiled identity it must, he argues, be supplanted and a new drug-free identity constructed and put in place. Biernacki wrote that not all his participants were motivated to be drug-free, nor did they feel they had a spoiled identity (and consequently did not experience stigma) about their drug-taking lifestyles a point supported by Radcliffe and Stevens (2008) in their study of 53 people with problem substance use issues in England. However, even when they did, they could build a new un*spoiled* identity, which enables them to self-identify as being "in recovery" or "recovered" from their spoiled identity.

Other researchers have also suggested that the motivation to become drug-free often precedes one of two exit routes from drug use. These are "the rock bottom" experience (for example a near-death experience, overdose, illness, or suicide attempt) and the "rational decision/s" (a culmination of experiences leads to a conscious decision to stop drug use) following an "arc" from addiction to recovery (Waldorf and Biernacki, 1981; see also Kemp, 2013; Nettleton, et al. 2011; Laudet et al. 2009). In 1979, Waldorf and Biernacki citing Waldorf (1970) and O'Donnell (1965, p.286), wrote that "…seldom is heroin used uninterruptedly. Occasionally, individuals initiate an abstinence from use themselves", and it is within these abstinences that people who use heroin drift away from their behaviour associated with their substance use disorder. Consequently, a small percentage of the participant group just "drifted" away from drug use towards other more engaging pursuits, for example, parenting, relationships or employment. They rejected their spoiled identity and subsequently discovered and constructed new drug-free identities independent of professional assistance, albeit "only to eventually drift back to regular use", a common finding in many studies.

Instrumental to repressing opiate use and developing a new non-drug using identity include staying away from people who are known to use drugs, making a new drug-free life, filling the time that drug use took up with something else, and engaging with paid employment and support from significant others (those who do not use illicit drugs) (Keene and Raynor, 1993). What this represents is the construction, not only of a new identity but a new "drug-free" life beyond the influence of drugs and their use often within a new environment. Biernacki (1986) argued that eventually the "addict's" new life, with its associated benefits, such as social acceptance, economic improvements and emotional status, act as motivation to not use drugs again, thereby perpetuating a drug-free life, with a new drug-free identity. This fits well where people can and want to remove themselves from their immediate environment and social group.

Biernacki surmised that many “addicts” attained “natural recovery” and rejected the then traditional concept that opiate addiction is both chronic and untreatable, citing that “natural recovery” occurred before professional interventions were available and without them when they are available. He identified from his study that, even when available, people who use drugs, for whatever reason, do not always engage with professional help. Rather, they autonomously reject the notion of a spoiled identity and achieve abstinence. Biernacki wrote that once an “addict” accepts his or her “spoiled” identity, they could begin to dismantle and reconstruct their “drug identities” living fulfilling lives without engaging with recovery models. Biernacki’s theory leaves unanswered questions surrounding what constitutes a spoiled identity with regards to drug use specifically, why a drug using identity is negative and when is it assigned in their drug use careers, who assigns and removes spoiled identities to people who use drugs within society when this does happen and why.

McIntosh and McKeganey (2002), explored participants’ recovery journeys by conducting in-depth, semi-structured interviews with self-reported “recovering” people (n42) who had used drugs in Scotland. They explored how people who used drugs engaged with their concepts of recovery, identifying their rationale for engagement and what, if anything, helped or hindered their recovery pathways. McIntosh and McKeganey (2002, p152), found participants reported that their identities were “seriously damaged by their addiction” indicating that recovery equates to the restoration of their “non-addict” identities to the exclusion of alternative identities participants may enjoy, such as being a parent, friend or employee. These were often, however, the very identities that commenced drug use in the first instance.

McIntosh and McKeganey’s (2002) participants revealed that their recovery extended to abstinence, reduced drug use and harm reduction i.e., substitute prescriptions of methadone. Similarly, to Biernacki, they reported instances of “natural recovery” achieved without professional assistance, identifying it as a simple reversion to an older non-drug-using identity. As with Biernacki’s findings, McIntosh and McKeganey (2002) identified that, before their participants challenged their drug-using spoiled identities, participants often reported hitting “rock bottom”, which leads to an identity transformation process where they reconsidered and then reconstructed their identity. Rock-bottom was signified by a specific event within their lives, such as a near-death experience. After hitting rock bottom, they appear with a new non-drug-using identity, and although citing abstinence from heroin use, recovery did not extend to abstinence from other drugs or reflect the 40% relapse rate.

McIntosh and McKeganey (2002, p.1508) wrote that “recovering addicts sought to draw a distinction between the person they believed themselves to be “at heart”, the person they felt they had become because of their drug use, and the person they felt they could become now that they were no longer dependent upon illegal drugs.” They did not, as Biernacki had reported, find that people who use drugs drift away from their drug use or indeed make a rational choice to become abstinent, evidenced in part by the relapse rate amongst their participant group. McIntosh and McKeganey (2000, p.1509) report that “in many cases, the addicts’ accounts of their recovery may have been constructed in interaction with representatives of drug treatment agencies” suggesting their voiced meaning of recovery is influenced by interactions with drug agency staff and represented “official” constructions rather than being individually constructed from their subjective meaning.

Participation in recovery, McIntosh and McKeganey (2002, p.51) found, was emphasised by the meaning participants gave to their drug use and associated behaviour. Unlike Biernacki’s findings, recovery was contemplated when drug use was considered negatively by the individuals and they displayed “characteristics that are unacceptable both to themselves and to significant others” characteristics which led to isolation, ostracisation and stigmatisation. They found drug use, and the associated lifestyle became unpleasant and drug-using acquaintances and relationships, which people who use drugs considered mistrustful, exploitative, and unwelcome were, like Biernacki’s findings, to be rejected if a new drug-free identity was to be attained.

Briggs' (2004) study on “crack users” in London, highlights the role stigma in addition to moral shame, the substance, and structural conditions have in shaping identities, arguably compromising the ability of people to take responsibility for their actions. Briggs study revealed participants employ active self-management to help counteract negative stereotypes, rejecting their "crackhead" identity to maintain social stability and their self-respect. Active self-management helps to highlight their efforts to live “normal” lives similar to those people who do not use drugs. Rejecting a "crackhead" identity is not considered a symptom of addiction but a rational response to protect their social stability and personal dignity. This challenges the perception of “crack users” as fundamentally different from other people, by emphasising common human behaviours and desires. “Crack users”, however, face everyday obstacles such as homelessness and lack of recovery services, hindering their ability to

construct stable identities. Briggs also found that participants placed themselves along a continuum of social organisation, which he called from "High Society to Low Life crack users". He posits that "crack users" can be viewed as both "victims and perpetrators" and this duality reflects their complex identities ultimately contributing to their marginalisation and underpinning their "spoiled identities".

Notably, both McIntosh and McKeganey's (2002), and Biernacki's (1986) studies report that attempting to forcibly change a "spoiled identity" through, for instance, the criminal justice system or societal pressure (often noted in the application of recovery) could be counterproductive and less effective than when people who use drugs actively and autonomously seek help. An apparent issue is that formal systems reinforce spoiled identities (and in doing so associated behaviour) by pejoratively labelling people who use drugs as "addicts", "deviants" or "criminals". This leads to negative implications for their social identity and may reinforce their own and societal beliefs and values (self-fulfilling prophecy) about addiction rather than challenging and changing them.

Neale et al. (2011), in contrast to Biernacki and McIntosh and McKeganey, foreground *practice* and argue that new practices lead to new identities. They too, claim the construction of a new identity requires people who use drugs to create a new lifestyle. Drug-using associates and relations need to be terminated and a new environment is required to provide anonymity, which may be challenging where, as identified previously, a new environment is not wanted or available. Although not unique in their findings, Neale, et al. (2011) found that new identities may take longer to construct where drug use is prolonged because chronic drug use reinforces drug-using identities and behaviours acting as barriers to reconstruct a drug-free identity. Thus, undoing a "spoiled identity" is, as Goffman intimates, a difficult and protracted affair which is impacted by the extent to which people who use drugs are embedded and entangled with drug-use, drug-using and non-drug-using peer groups, families and communities.

Neale, et al. (2011) acknowledges that, although such language is outdated, the impact of a "spoiled identity" holds a powerful impact. Outdated language causes lasting and ultimately stigmatising effects on key understandings underpinning recovery within sociological circles and on people who use drugs themselves. To regain socially accepted identities, conformity to accepted practices and values, i.e., social norms must be adhered to. Identities can be achieved through self-management and by interacting with suitable services, to which they give more

emphasis than earlier discussions. Interaction with "treatment services" to achieve this was highlighted as necessary within *The Road to Recovery* strategy (Scottish Government, 2008) and by Keene, (1997), McIntosh and McKeganey (2002), Neale, et al. (2011) and Nehlin, et al. (2020) who all intimate treatment services enhance positive recovery outcomes.

Best, et al. (2015) question Biernacki's findings that people who use heroin require to be free from their drug-taking environment and acquaintances to construct new identities. They support McIntosh and McKeganey's (2002, p.1504) findings relating to the ability of people who use drugs to "reconstruct themselves", "their lifestyles" or a "provision of convincing explanations for their recovery". Best, writing in Robinson and Hamilton's (2016), *Moving on from crime and substance use: Transforming Identities,* comments that a non-drug-using identity establishes a "stake" in both present and future society, providing a tangible reason for them to reject drug use. A "spoiled identity," he notes, could then be replaced by a regenerated or new drug-free identity too precious to give up through a return to drug use. His discussion aligns with "New Recovery" concepts and what happens beyond abstinence, i.e., becoming "a contributing member of society" (Scottish Government, 2008, p.23). Best, et al. (2015, p.3) also highlighted the value of sociality to recovery, writing that the social context in which change occurs has little emphasis from scholars and individual identity change rather than social identity change was dominant. They argue that social identity changes not only initiated recovery pathways but is also valuable to maintain it. They found where drug-using social contacts were replaced by groups of non-drug-using contacts, people with substance use disorders' recovery fared better and lasted longer and that the "best (recovery) outcomes were more socially connected, particularly with social groups whose norms were not supportive of continued substance use".

Sociologists emphasise the constructed nature of spoiled identities and their social function which are underpinned by dominant negative discourse and the illegal nature of illicit drugs, drug use and those who use drugs, all of which can be constructed as "deviant" (Becker, 1964). In contrast, all non-drug use, (and by proxy people who do not use illicit drugs), is constructed as desirable. Dahl (2015) notes the deviant identity defines the individual and defines their behaviour regardless of any potential alternate reality. Contemporary studies into "identity" include Hill and Leeming's (2014, p.19) study exploring the "reconstruction" of six ex-alcoholics' identities which identified the need, associated with AA 12-steps, for "accepting an identity as an addict as if this were an indicator of self-understanding and awareness, rather

than a mark of stigma or shame". Hill and Leeming go on to argue that "positive identity often seems reliant on connection with and validation from others", "others" being those who do not use illicit drugs. Changes in an individual's drug use are simply not enough, neither is change in individual identity enough for validation to happen. Recovery requires embracing a non-drug-taking identity, severing ties to drugs, drug-using networks, lives, environments and people who use drugs. Fitting with the current, more socially focused, and accepted understandings of recovery. However, Becker (1964) noted that if drugs were not criminalised then no rules could be broken and no enforcement could be applied, ergo: no deviance.

Dahl (2015, p.182), on the other hand, challenges the notion of identity construction in her study of 25 people who used cannabis conducted in Norway, stating: "they did not simultaneously want to establish a radically new identity or re-establish an earlier version of self". Dahl's (findings) align with Neale, et al.'s (2011) findings on practice and identities and Dahl found her participants were satisfied with their drug-using identities and did not want to change them, just the drug use *practices*. Alcohol and cannabis, however, carry different levels of social criticism, acceptance, and stigma to heroin and the degree to which addiction and drug use are considered deviant within peer groups and communities is fluid and changeable over time and across locations (Yates and Malloch, 2010).

At this point it is also worth exploring Earp, et al.'s (2019, p.151) discussion. They considered the identity change of people who use drugs from the perspective of those who do not. They found that "becoming addicted to drugs consistently led to greater perceived identity change in our studies than recovering from addiction", questioning the acceptance by society of people with an "addiction" who were seeking or in recovery. In urban areas, however, people who use drugs can arguably find anonymity even in densely populated areas, where they can blend in and attain anonymity in the throngs of the urban populace. Rurality by contrast provides little anonymity despite the geography, Earp et al.'s findings, therefore, have potentially serious implications for people who are recovering from drug use in a rural setting.

In summary, the imposition of a "spoiled identity" or prevailing negative identity which overshadows all others demonstrates the power of the identity concept, especially where contemporary research perpetuates and reinforces traditional values associated with identity. The concept retains an influence on societal views and attitudes toward addiction and recovery, creating a lack of trust in people who use drugs' recovery pathways and any commitment to

alter their identities, with the result that communities use the spoiled identity label more often and pejoratively. This leads to a reluctance by communities to accept individuals into mainstream society, even where there is a willingness to change, and ultimately slows the identity restoration process (McIntosh and McKeganey, 2002).

Contemporary research, however, (Hill and Leeming, 2014; Dahl 2015; Best, et al. 2015; Bathish, et al. 2017 and Earp, et al. 2019), argues that identity is beyond simple individual control, identifying that it is fluid, guided, formed, and developed through social strategies, interactions, procedures, and experiences. Identity as Neale, et al. (2011) point out, can be multifaceted, and the application of a single (drug using) identity excludes other potential identities such as a partner, parent, or employee. The application of a simple societal label of deviance to behaviour such as drug use (or addiction) therefore may not lead to a generally accepted consensus of what equates to a spoiled identity. Continued research on identity in addiction and recovery is necessary to expand the discourse on identity and "natural recovery". In this next section, I consider "recovery capital".

3.6 Recovery capital.

Emerging slightly later than research on the role of identity in recovery, the concept of "recovery capital" gained currency in sociological analysis in the late 1990s. The term "recovery capital" can be traced back to the influential work of French sociologist Pierre Bourdieu, who introduced the broader concept of "capital" into sociological discourse in the 1960s. Bourdieu's theory asserts that various forms of capital are linked to relational labour across different fields with their value contingent to a specific field allowing them to either elevate or demote individuals within society (Bourdieu 1989). Bourdieu identified four primary types of capital, which constructs an individual's social class, (Bourdieu, 1989; Brown and Szeman, 2000; Grenfell, 2012; Rogosic and Baranovic, 2016): economic capital (akin to a Marxist economic concept), social capital (encompassing the ability to draw on social resources from one's position within a social hierarchy), cultural capital (representing the ability to leverage knowledge, education and skills possessed) and finally, symbolic capital.

Symbolic capital as defined by Bourdieu encompasses the recognition and consideration an individual receives, that serves as a basis of social existence. The recognition is an automatic process that happens when an individual enters a "field", an arena of production. All fields have their own "doxa" which are a set of accepted principles and norms, which are ascribed to

the individual by others upon entry. The assigned attributions, either positive or negative, are contingent on the perspective of the group and their views of the individual, the group itself, can also be influenced by the individual and their perspectives. Bourdieu (1989) theorised that, as individuals develop within their society, they attain and use different forms of capital in different ways to elevate and manoeuvre themselves through it. Bourdieu (1989, p.14) explained that "within the social world itself and not only within symbolic systems (i.e., language or myths), objective structures independent of the consciousness and will of agents, are capable of guiding and constraining their practices or their representations." This then, highlights the intricate relationship between individuals and social structures, identifying the influence objective structures exert in the social realm.

Granfield and Cloud (1999, p.1972) are credited with the conceptualisation of "recovery capital" to the context of drug addiction. In their study of "natural recovery", (achieved without recourse to professional services), conducted in the U.S in the 1990s, they identified that internal and external resources that someone has to begin and maintain change (recovery) determined their success. They introduced the term "recovery capital", defining it as "the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation". Resources extend to those existing before an individual's involvement with drugs, during the period of drug use and through conditions likely to prevail in the future. Recovery capital extends to attitudes and beliefs that an individual has toward their past, present, and future as well as their mental health and other personal characteristics and attributes that can be drawn upon to resolve their substance use disorder. These are often clustered under terms such as personal, social and cultural capital.

Granfield and Cloud's (2001) study was in the U.S. where inequalities in drug treatment were and remain "raced". Singer and Page (2014) note that historical differences in the treatment of people who use drugs in the U.S. were dependent on ethnic origins, with White people traditionally encouraged into recovery services which were developed to meet their needs. Conversely, Black people were and arguably remain overlooked for the provision of recovery services and are also at higher risk of prosecution, ostracisation and incarceration because of drug use. In many areas of the U.S., publicly financed recovery is chronically underfunded and people who use drugs who engage with the harm reduction model are often ostracised and stigmatised for not embracing abstinence, which is a societal expectation in the U.S. Granfield and Cloud (2001), found that identity approaches do not account for inequalities in the

experience of All fields “natural recovery”, thus they did not consider identity important or of any relevance to recovery. Instead, they identified that the resources people who use drugs draw upon positively influence their recovery pathways.

Granfield and Cloud’s (2001) study includes 99 participants from White, middle class and stable working-class backgrounds. All but 4 had completed a “high school diploma” and 55 were professionals or worked in business, leading Cloud and Granfield (2008) to conclude that education and perceived intelligence can be an integral part of recovery capital. Their homogenous participant groups’ success in achieving abstinence reflects their social status and access to resources, not accessible to most Black people who used drugs. Granfield and Cloud (2001) investigated “key” personal and “social resources” that people who used drugs reported they had needed to recover successfully and found that recovery capital such as professional services, employment and relationships provide various levels of support. For instance, not only does the individual benefit from employment per se, i.e., the structure and respect that brings, they also benefit from the money they earn and the experience they accrue, along with identifiable social and material benefits to their significant others and children. Granfield and Cloud explain financial capital and work experience, for example, attract respect from others, enhance feelings of worth and achievement for the individual and provide access to colleagues who do not use drugs and their non-drug-using lives, their support and advice and potentially, medical insurance from their employer. Cloud and Granfield (2008) argued that the more recovery capital a person has, the greater their chances of engaging with recovery, and attaining and maintaining remission from their addictive lifestyle (Figure 1).

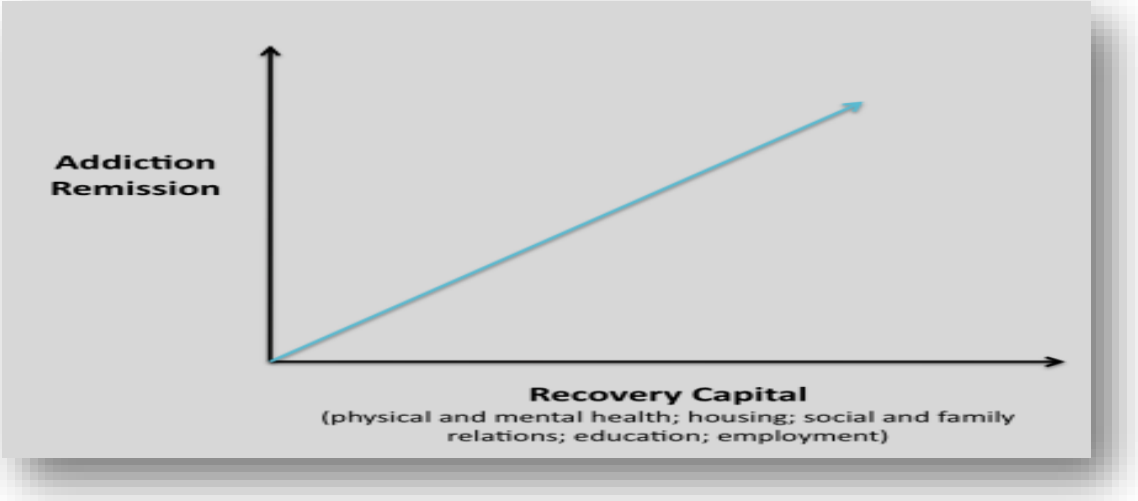


Figure 1 – Bi-axial formulation of addiction and recovery (Edwards and Gross, 1976; Grandfield and Cloud, 2008; Kelly and Hoeppner, 2014)

Cloud and Granfield (2008) acknowledge that initiation of recovery from drug use can be prompted by "avoidance-oriented" conditions. Examples extend to individuals being "fed-up" with their drug-taking lifestyles or undergoing health scares such as, hitting "rock bottom" or "near-death experiences". These reasons align with those identified by scholars of other recovery pathways such as Biernacki, (1986), McIntosh and McKeganey, (2002), Best, et al. (2015) and Lancaster, et al. (2019). Furthermore, Cloud and Granfield (2008) highlight that removing a person from their immediate drug-taking environment and stopping access to drugs (e.g., through incarceration) and particularly where there is a risk of losing social ties are significant motivators for accessing recovery. Sobel et al. (1992), specifically notes the relevance of this dynamic, which they state is of particular significance to mothers who use heroin because of the potential for their children's removal from their care by the authorities.

Granfield and Cloud (2001, p.270) discovered that "approach oriented" goals such as a positive pull of a better life, associated with employment, and stable relationships for instance, are effective in motivating people to abstain from drug use. These findings align with Waldorf's (1983), theory that suggests conditions such as employment, relationships and a stable life enhance the prospects of recovery. Laudet and White's (2010) research into recovery capital further corroborates this, emphasising that "approach orientated conditions" such as employment, housing, education, and social relations were identified as priorities for recovery by people who use drugs. It is of course, noteworthy that some people who use drugs already possess such attributes.

Contrastingly, Best, et al. (2009) argue that, although "avoidance-oriented factors" may be reasons for initiating recovery, they may not sustain it over the longer-term. Granfield and Cloud (2001) contend that most people who use drugs achieve recovery without recourse to professional services or support. This observation aligns with the findings of Biernacki (1986), and McIntosh and McKeganey (2002) who argue that recovery capital, when accessible, provides a "structural framework" for the occurrence of "natural recovery". This is due to the availability of resources that can be harnessed and that influence recovery pathways.

Best and Laudet (2010), attempt to operationalise Cloud and Granfield's concept, presenting it in four components in an endeavour at quantification so it can be applied to people who use drugs to evaluate if they possess recovery capital (Box 1).

Box 1: Concept operationalisation.

1. Social capital - the sum of resources that each person has because of their relationships, inclusive of support from and obligations to groups to which they belong: Familial membership can provide support, however, it also entails commitments, dedication, and obligations to family members in return.
2. Physical capital – tangible assets, for instance, property, money and material goods that may expand the person's recovery options, i.e., having the resources to move from their area where drugs are prevalent, paying for specialist addiction treatment or affording a lawyer.
3. Human capital - incorporating social and employment skills, positive health, future goals and hopes and any personal resources that will enable the individual to prosper. Human capital such as a good education and a sound intellect is considered desirable, as these assist in problem-solving and learning that is considered necessary whilst initiating and engaging with recovery.
4. Cultural capital - encompasses a person's values, beliefs and attitudes. These build the links to social conformity, which in turn allow the person to integrate with dominant social behaviours and allow them to integrate or re-integrate into society.

(Best and Laudet, 2010, p.39).

Best, et al. (2012) strive to quantify recovery capital into levels of "life quality" from low to high. They argue the greater the accessibility to higher levels of recovery capital, such as professional services or friends who do not use drugs, contributes to better "life quality". Consequently, this increased quality of life enhances opportunities to engage with recovery pathways, coincidentally lowering the risk of relapse. They found the greatest influence in challenging addiction careers were environmental factors, which they compare with personal capital (meaningful activities and self-esteem) and social skills.

Cloud and Granfield (2008) identified that, although addiction spans social boundaries, the capacity for recovery is not uniformly distributed due to societal inequality, rather than individual identities. Affluent members of society exhibit a higher incidence of recovery attributable to the depth and diversity of available resources. Access to different kinds of capital is influenced by socioeconomic background, race, and religion. For example, in the U.S.

employment-population ratios between Black and White communities are similar at 60%, White households' median incomes, however, are $70,000 compared with Black households' median incomes which are $40,000. This disparity is reflected in other employee benefits, such as healthcare (Yearby and Brennan, 2018; U.S. Bureau of Labor Statistics, 2020), resulting in potential recovery capital that is unevenly distributed. Thus, recovery outcomes are dependent on the resources available to support people, which are greater in affluent populations (Cestone, 2019; Silverman, 2019; Alexander, 2011).

Data from Cloud and Granfield's (2008) study involving 312 people recovering from heroin and crack-cocaine addiction drawn from inner-city ethnic minorities in the U.S. indicates that recovery pathways are prolonged, and there is a higher incidence of relapse in areas of deprivation. The authors attribute this phenomenon to low availability of recovery capital, lack of investment and poor infrastructure in deprived areas. Individuals new to recovery pathways, and lacking experience in that "field", often struggle to achieve abstinence even where recovery capital is accessible. However, Cloud and Granfield observed that where there was little individual recovery capital, professional services were beneficial. Conversely, where recovery capital was abundant, professional services were often not sought. Notably, where there were no professional services and recovery capital was low, higher incidence of "natural recovery" was observed.

Holt and Treloar's (2007) study of 77 individuals in recovery in urban Australia revealed that the majority came from socio-economically disadvantaged backgrounds and lacked recovery capital. This fits with global patterns of drug addiction. Consequently, they argue, their participant's ability to engage in "self-care" may be compromised because of impoverishment and its associated factors, rather than their drug use. In addition, studies by Lyons and Lurigio (2010), Neale, et al. (2015) and Best, (2016) found that people who use drugs and lack individual recovery capital face additional challenges in their recovery. Their recovery pathways are compounded in areas where there is a lack of "community social capital", which includes factors such as employment and education, noted as being beneficial, for recovery alongside a drug-free environment and professional support.

Best, et al. (2012) used semi-structured questions to study 98 people in recovery from heroin use within an urban setting. They found those people who could develop recovery capital in the form of resilience, self-esteem, and motivation, are more likely to attain and then sustain

recovery from drug use. Granfield and Clouds (2001) had also outlined that both internal and external recovery capital were deemed essential to recovery. They argue these forms of capital are necessary to initiate and sustain recovery from drug and alcohol dependence. Best, et al. (2012) also found that people who used drugs are unlikely to engage with or have access to recovery capital elements such as education, employment, and housing. The lack of engagement can be attributed to society's negative perception and rejection of people who use drugs and their associated lifestyles, even when engaging with recovery processes. However, Granfield and Cloud (2001) observed that even in environments where recovery and social capital was considered scarce or challenging to find such as in rural settings, individuals could still have "inherent recovery capital", such as self-esteem or a motivated personality. Rural areas arguably, offer distinct types of connections (capital) to people who use heroin, which are explored in later chapters.

Expanding this discourse, Peluso and Peluso (1988) and Gavriel-Fried et al. (2020) identify a strong belief in faith and spirituality as recognisable sources of recovery capital with concepts such as "God" and "Hope" playing significant roles. Laudet and White (2008) also identified faith and spirituality as "powerful ingredients" in either stopping addiction in the first instance or as part of recovery capital. This aligns with the philosophy of the U.S. dominant 12 Steps programmes of recovery, which emphasises abstinence through belief in a "Higher power" and hope in a better future.

Best, et al.'s (2012) study based in urban Scotland involving people in recovery from alcohol (n=107) and heroin (n=98) use identified recovery patterns. They identified recovery being greatest where peer, not professional support, was prevalent, consistent with AA's 12-step recovery principles and protocol which emphasises the importance of peer support in recovery. Granfield and Cloud (2001), had previously found that intimacy from relationships is a dominant feature of recovery capital in recovery pathways. People who use drugs, however, often alienate friends and family members, simultaneously irreparably spoiling relationships due to their drug use and associated activities. However, Granfield and Cloud (2001) argued that, in their experience, relations can be "reconnected" when opportunities arise, thus reasserting and strengthening an individual's recovery capital and their resolve to engage with recovery pathways. This draws conceptualisations of recovery capital and identity in recovery closer together as the principles of reconnections often equate to identifying change within the context of engaging with recovery capital.

In her feminist perspective, Ettore (1992) considers gender differences in accessing recovery capital. She notes that women's recovery is greatest where social recovery capital (defined by Ayed, et al. (2020) in the form of stable accommodation, regular income from benefits, and a good social network) is optimal and accessible. However, Ettore concludes that drugs services were "pro-male", unhelpful and unengaging for women who use drugs. By utilising recovery capital, Ettore (1992, p.93) suggested women who use drugs could become "superior individuals by increasing the discipline of the mind rather than trying to control their bodies". She highlights that, for women, "recovery capital" such as pregnancy and childbirth were major proponents in initiating recovery. However, these factors also led to relapse if children were removed from their care. Yet Ettore felt uncomfortable identifying children as "recovery capital" fearing women may intentionally get pregnant as a recovery pathway to motivate their engagement with recovery services. Despite this, Ettore (1992) acknowledged her stance means women who use drugs were often reliant on "natural recovery". An observation that aligns with Smith's (2014) findings in her study of women with intravenous substance use experience in rural Wales, where there was a prevalence of "natural recovery" due to their limited choices being largely influenced by overarching male dominance, expected performativity and the potential for their children's removal.

Notably, Granfield and Cloud (2001) and Cloud and Granfield (2008) introduced the concept of "negative recovery capital" in the context of recovery. They described it as a process in which personal circumstances, individual attributes, attitudes, and values inhibit engagement with recovery pathways, invariably impeding or leading to the rejection of recovery, even where access to other forms of capital were available. Lyons and Lurigio (2010) contend an excess of recovery capital too quickly can be overwhelming for people who use drugs and may lead to a paradox of increased heroin use or relapse as a result. Best, et al. (2016) posit that negative recovery capital represents "barriers", for example, to access paid employment. These barriers, they argue, impact on developing supportive social networks, meaningful activities, and a sense of purpose and hope. Consequently, these challenges can impede the transition of early recovery initiative into stable long-term recovery. "Negative recovery capital" also manifests paradoxically, in that recovery capital apportioned to encourage engagement with recovery pathways acts as a barrier, for instance state benefits assigned to "addicts" are withdrawn when recovery is realised.

Granfield and Cloud (2001) and Lyon and Lurigio (2010) demonstrate that access to different forms of recovery can be conflicted. People who use drugs, for instance, benefit by moving from their environment to escape drug use, while on the other hand, the environment in which they live provides crucial social and support networks. Furthermore, professional and support services may be beneficial for recovery, but evidence reports most people who use drugs recover through natural recovery pathways. Natural recovery pathways, however, cannot be monitored so there is no evidence to clarify what percentage of people who use drugs recover (stop using drugs) without professional interventions. Uncertainties also persist in the recovery capital literature, about, for example, the influence of change and what change means for and in recovery. For instance, it is uncertain if change increases or decreases then impact an individual's subsequent drug-taking behaviours and activities. Neale, et al. (2015) also highlight the challenges of assessing and quantifying recovery capital, with Groshkova, et al. (2013, p.192) citing a "lack of verification" arguing assessment tools are limited in measuring or analysing recovery capital and any resultant effect.

The U.K. drug strategy, *Reducing Demand, Restricting Supply, Building Recovery,* nonetheless, draws upon the concept of recovery capital. The strategy asserts, "One of the best predictors of recovery being sustained is an individual's "recovery capital", (H.M. Government, 2010, p.18). This acknowledges it as an integral part of its recovery strategy. Notably, the Scottish strategy diverges from its English counterpart by not incorporating or emphasising the concept of recovery capital. In contrast, its Scottish equivalent, "*The Road to Recovery"* (Scottish Government, 2008), maintains a distinct focus on the individual, and their identity, whom it perceives as a danger to themselves and others due to their illicit drug use.

In summary, the concept of recovery capital stands in contrasts to that of identity recovery and was developed, at least partly, because of the observation that recovery is highly socially patterned in favour of those with the most resources and capital. Sociological research into the role of recovery capital provides a valuable perspective to examine the transition of people who use drugs through recovery pathways. Quite how recovery capital or "natural recovery" manifest in rural settings is uncertain as most of the evidence is drawn from urban studies. Rurality, however, offers distinct access to resources, with unique challenges and opportunities concerning addiction, recovery, recovery capital and negative recovery capital. These aspects will be explored further as my thesis progresses and through the findings of my research. My

next focus will be on the consideration of the "everyday life" of people who use drugs in relation to their everyday practices and what recovery means to people who actively use heroin.

3.7 Recovery in everyday life.

Researchers in the field of addiction frequently overlook the mundanity of everyday practices and life with the limited available evidence predominantly drawn from urban settings. However, recent years have seen a growing recognition of the significance of individuals' everyday actions regarding addiction, drug use, and recovery. This understanding has illuminated the varied experiences people have with drug use and recovery, highlighting why some people who use drugs seem to recover more readily than others (Gabe, et al. 2004; Fourcade 2010; Neale, et al. 2012; Flore, et al. 2019).

Defining "everyday life" is far from straightforward, as it holds different meanings in different contexts to different actors. Adler, et al. (1987, p.218), however, clarify that the sociology of everyday life is:

> "An umbrella term encompassing several related but distinct theoretical perspectives: symbolic interactionism, dramaturgy, phenomenology, ethnomethodology, and existential sociology".

Adler, et al. (1987) explains that the application of the "umbrella term" in many ways detracts from and hinders the development of everyday life as a sociological concept. Scholars and researchers, they contest, simply choose, and apply whatever theories they want, combining them as they please and then making autonomous judgements concerning affiliating themselves or not, with the everyday life label. I will attempt to operationalise everyday life for the purposes of my study.

Lefebvre (1991, p.21) defines the everyday as the "illusion and truth, power and helplessness; the intersection of the sector man controls and the sector he does not control." The everyday then, is constant; it is a space where life takes place in all its many forms ready to be observed. Within his seminal work "The practice of everyday life" de Certeau (1984), draws on the works of academics such as Michel Foucault and Pierre Bourdieu to identify everyday life, describing it as the enactment of ordinary people's routine lives as they individualise "mass culture" to maintain their autonomy from pervasive forces, such as politics and the judiciary. The influence

of such forces on people who use heroin in a rural setting and their recovery, however, is uncertain yet arguably important.

Within other analytical frameworks such as identity and recovery capital, "everyday" issues, appear mundane, unimportant and are often overlooked by scholars who forefront "dangerous and harmful" aspects of the lives of people who use heroin. Nettleton, et al. (2011) note researchers in the field of drug use miss and overlook the mundane everyday activities of people who use drugs, from simple interactions, nutrition, and hydration to defecation. It is not that sociological scholars did not historically understand everyday life in society or indeed value it; rather, as Adler et al. (1987) and Russon (1994) explain, they simply never paid much attention to it. However, Neale, et al. (2012), Nettleton, et al. (2011) and Weinstock, et al. (2008), argue that these mundane everyday aspects of lives have an enormous bearing and impact on the emotional and physical well-being of people who use drugs and may impact their drug use and recovery pathways. Everyday life explores the multiple social realities experienced by individuals, even those that share close and prolonged proximity. By omitting them from research studies means a potentially important perspective is left undiscovered and unexplored.

Neale, et al. (2012, p.199) argue that analysis of everyday activities is essential to the understanding of drug use and recovery, as they present a contrasting perspective to other analytical frameworks. They define everyday life in the context of drug use and addiction as people who use drugs reporting "wanting to be "normal" by "experiencing both the positive and negative aspects of everyday life" in the same way as people who do not use drugs. The fundamental everyday activities of daily life relate to independent and autonomous living, which is generally accepted to meet an individual's physical, social, and subsequently, mental health needs. These are basic activities such as "eating, drinking and personal hygiene" (Mlinac and Feng, 2016). The issue with the application of macro-sociology is that it is often deterministic when considering individuals within society, traditionally depicting actors as either:

> "Tabula rasa internalizing norms and values of society out of a desire for group membership or homo economicus, developing social, political and ideological characteristics as a result of their class membership" (Alder, et al. 1983, p.218).

Thus, such fundamental everyday activities are omitted, but may subconsciously incorporate drug use, recovery behaviours and associated decision making.

An individual's body retains a tally of everyday lived experiences of physical and social engagement that bear witness to the contexts and conditions of such experiences and encounters which can be tapped into. Merleau-Ponty, (2004, p.6) explains that individuals are "not an abstract absolute consciousness but are in some way inserted into the world of space and time". Herriman (2020, p.27) added that:

> "If you compile all your culturally specifically bodily practices, these effectively change your muscles, possibly your mental process, and even the bones of your body. Now if your body is changed, your perception of the world is changed."

Herriman's point is of particular interest when applied to people who use heroin who live in rural settings where anonymity is a moot point; how the everyday lives of those people who use heroin fit with the rural community they live within and what influences they exert upon each other needs to be explored to be understood.

By studying everyday life and studying individuals or groups and their practices within their natural context in the everyday social world, naturally occurring interactions can be observed and questioned. This allows meaning, perception, and feelings to be extracted (Adler, et al. 1987). Everyday life extends to individual actors, from their cognition, values, and beliefs to their physical "being" and how they influence and impact their development and socialisation. Everyday life also applies to both the social order and structure that is created from this and the reciprocation inherent within that relationship. Actors, social structures, and order are not independent or autonomous from each other, and as a result, influence each other. For instance, as cultures change, or when individuals change their culture, their everyday behaviours, values and actions are also subject to change. In contrast, the culture in which they reside may also change (whether they are present or absent) because of the influence the individual's behaviours, values, or actions have. Where there is no integration, then according to Fredrickson and Joiner (2002), the individual is at risk of being marginalised and ostracised, such as in the case of people who use heroin, and they are then subject to the negative impact that being ostracised and marginalised can bring.

Everyday actions such as sleep, diet and exercise affect people's self-esteem, resilience, and ability to cope with their everyday lives (Crossley, 2007; Fredrickson and Joiner, 2002; Neale, et al. 2012; Petteway, 2019). Nettleton, et al. (2011), identify that where and when an individual's body functions "normally" then little attention is paid to it, and their everyday continues unabated. Attention is, however, drawn to a "dysfunctional body"; here medical advice is sought as is engagement with recovery to return the individual to their previous level of well-being (Leder, 1990). However, "mundane" everyday complaints of people who use heroin such as fear, loneliness, anxiety, constipation, pain, or dehydration may be viewed differently by healthcare workers, because a "drug-using body" is viewed differently (medically and socially) to a "non-drug-using body." The associated stigma attached to people who use drugs may then engender circumstances that result in them being deprived of appropriate physical or mental health care. Consequently, perpetuating a cycle where their emotional and physical health is adversely affected. Simultaneously, this stigmatisation reinforces a continuation of their drug use, whilst detrimentally influencing any interaction with recovery services and recovery capital (Telfer and Clulow, 1990; Bell, et al. 2002; Duterte, et al, 2011). Equally, their happiness, contentment, love, and joy in life may also pass unacknowledged.

Nettleton, et al.'s (2011, p.357), conducted an analysis of qualitative interviews from 40 people in recovery from heroin use. They found that the "everyday" of their participant's was essentially, as one participant articulated, "Wake up, make money, score and use." The profound impact of heroin perpetuates this state as it negates self-awareness and self-consciousness and dampens everyday emotions (happiness and sadness) and physical needs (hunger and pain). These, however, become a stark reality in heroin's absence as the unmet needs of the body are realised and thus perpetuate the cycle of use.

The everyday of people in recovery, free of habitual and urgent need of heroin, were starkly different. They were found to engage in activities and draw upon recovery capital such as listening to music, watching television, employment, and everyday societal interactions. Nettleton, et al. (2011), argue these activities play a pivotal role in promoting physical and psychological well-being as they foster vital elements such as social interactions, regular meals, defecation, and sleep. The emphasis on routine activities is conducive to reinforcing and enhancing recovery pathways. The authors argue that people in recovery, similarly to the identity model of recovery, can draw upon and build on pre-drug use/use-concurrent identities

and can consequently develop and add new routines and practices to their recovering identities, which are central to recovery pathways.

Drumm, et al. (2005) conducted a qualitative interview study in the U.S. that involved interviewing chronic and injecting people who used drugs. They found that they not only partake in but also report enjoying physical activities in the same way as people who do not use drugs. Their findings "conflicts with stereotypes that people who use drugs engage in few activities other than shooting up" (Drumm et al. 2005, p.623), which is arguably a stereotypical view of drug-using cultures and rooted in cultural expectations apportioned to drug-using behaviours. Supporting Drumm et al.'s findings, Neale et al.'s (2007) study employed structured questionnaires to explore how 606 people who use heroin "spent their spare time." This is an ostensibly "mundane" and overlooked practice of the everyday lives of people who use drugs. Their study found that 59% of participants reported at least one leisure activity, such a sport or hobby before their commencement with a treatment agency. This proportion rose to 86% almost 3 years later, indicating a positive correlation between recovery and engagement with leisure activities.

We can draw from Nettleton, et al.'s (2011), analysis that everyday activities such as partaking in leisure, for instance, are not regularly associated with mainstream heroin use. Such everyday activities contradict prevailing notions of addiction practices, consumed as they are with income generation and drug-using activities. This is exemplified by Drumm, et al. (2005, p.609) who wrote people who use drugs have "lives dominated by the search for the next drug hit." It could be contended that leisure activities are not inherently integrated into the everyday life and routine practices of drug-using culture. Indeed, leisure activities such as sport may even be considered incompatible with heroin use, by redirecting time which could be spent sourcing and using heroin. Crucially, by the end of Neale's (2007) study, only 69 individuals (11%) sustained contact with their treatment agency. A staggering 90% (541 out of the 606) reported a return to heroin use. A majority also reported involvement with an increased number of leisure activities. This observation indicates the capacity of people who use heroin, to continue its use whilst concurrently maintaining and participating in everyday activities and interpersonal relationships.

An exploration of everyday life is instrumental in highlighting such occurrences because, within mundane routines, situations can be identified, defined and explain how subjective and

unconscious meanings were identified. Everyday practices may highlight the reasons or causes of addiction and recovery. As Weinberg (2002, p.16) wrote "socially structured contexts of action" can play a key role in addiction and recovery. Notably, actors with substance use experience emerge as primary sources of information, as it is information gleaned from them expresses phenomena specific to the individual and their everyday (drug-taking and non-drug affiliated) routines and behaviours. Petteway, et al. (2019, p.103) state:

> "Literature has made clear that efforts to unpack the relationships between place, people, and people's health must be able to account for their multi-nodal, time-variant, and spatially specific place experiences".

The information they argue should be systematically gathered from the places and spaces relevant to the phenomenon, drawing from participant's embedded in "lived spatial realities and patterns of mobility" (Petteway, et al. 2019, p.105). This approach is necessary to mitigate any risk associated with overlooking findings or vital details intrinsic to the lived reality of everyday social, political, environmental, and economic conditions. Neglecting these contextual intricacies risks compromising an accurate understanding of participant's agency and accountability within a broader socio-environmental framework. The potential consequences for a radical reduction in collecting and presenting findings when exploring everyday practices, for example, when applying ethnomethodology for data collection during an exploration of everyday life, can lead to misrepresentation and bias findings. The application of a research design is explored in depth in the methods chapter.

3.8 Chapter conclusion.

In this chapter, I identified that the concept of recovery generated simultaneously with the concept of addiction identifying that the U.S. and U.K. have differing underpinning models. The U.S. adheres to an abstinence model, emphasising total cessation from drug use whilst the U.K. adheres to a harm reduction model, a more flexible approach which seeks to minimise risk and associated harms of drug use. I also identified three main sociological perspectives used to guide research on recovery.

Firstly, I explored the identity concept of recovery, a paradigm aligning addiction with a "spoiled identity", the loss of a non-drug-using identity. Within this framework a positive non-drug-using identity is supplanted by a new (negative) "spoiled identity". This spoiled identity

is linked with the assumed and applied “deviance” associated with illicit drug use. Recovery in the form of drug cessation and abstinence offers an opportunity to reverse a spoiled identity through engagement with non-drug-related responsibilities, relationships and activities, providing a means to return to “normal” society. A spoiled identity is instilled by society as a motivational force to cease illicit drug use whilst reinforcing stigma associated with addiction. Spoiled identities marginalise and ostracise people who for whatever reason, may not want or attempt to restore their non-drug-using identities. This can prompt those people who use drugs to rail against society and seek out those in a similar position, leading to countercultures and societal tensions (Boothroyd, 2006; Bancroft, 2009).

Secondly, and juxtaposed to the identity concept, is recovery capital. Recovery capital theorists argue the individualisation of recovery lacks scientific rigour as participants are reduced to mere “abstractions”. They contend that social realities, inequalities and conditions are filtered out and concealed. Recovery capitalist theorists argue that recovery pathways are diverse and in principle relate to the individual’s available resources and their perceived necessity. This extends beyond the traits, qualities, relationships, and environmental and social structures they occupy. These elements converge to form “tangible and intangible personal attributes, physical and socio-environmental structures, cultural dispositions, and related life circumstances that all affect one’s capacity to overcome substance misuse” (Cloud and Grandfield, 2008, p.1981). However, the distribution of recovery capital is not equal throughout society leading many individuals, particularly those from impoverished backgrounds to engage in “natural recovery” where “capital” is scarce (Bloomqvist, 1999). This aligns with Weinberg’s (2022) perspective that some people "in recovery" embrace a post-humanist practice of "freedom," utilising the diverse and practical resources available to them as they see fit. Where recovery capital is available not all avail themselves to it. Additionally, Cloud and Grandfield (2008) introduce the concept of “negative recovery capital” wherein dimensions traditionally considered essential on recovery pathways, transform into obstacles.

Finally, I considered approaches to “everyday life” which represents several sociological perspectives, leading Adler et al. (1987) to label it an umbrella term. Central to the concept of everyday life is its role in binding these perspectives to create a unified approach in its attempt to explore the ordinary and mundane aspects of everyday life and practices. The ordinary and mundane, however, contain social relations, social organisation, and social interactions, nuances and intricacies which hold rich and unique information often overlooked and bypassed

by researchers about drug use and recovery behaviours. Everyday life is as conceptualised as a skilled accomplishment of its active subjects (Kalekin-Fishman, 2013) and holds knowledge (conscious and unconscious) about phenomena such as drug use, addiction and recovery and how hegemonic ideology influences them.

The three analytical frameworks, in addition to abstinence and harm reduction offer diverse perspectives of recovery in drug use, although as concepts their scholarly applications have been applied to individuals in urban settings largely those who have recovered or are in recovery from drug use. Whilst a broad understanding of recovery is essential to meet my thesis aims, the concepts highlighted within abstinence, harm reduction, identity, recovery capital and everyday life also afford me recovery frameworks and models to apply their premises when collecting data. Understanding and applying the concept of recovery to people who use heroin in rural Dumfries and Galloway serves as a crucial step to locate recovery and elucidate what meaning recovery holds for my participants. Exploring such nuanced meanings will enhance my understanding of how recovery is conceptualised and experienced within a rural setting. In the next chapter, building upon addiction and recovery, I will visit my final literature review chapter on “space and place” as I look to construct and contextualise rural and the rural setting of Dumfries and Galloway.

Lost somewhere in the east of the region. Summer 2018.

Chapter 4: Space, place and rural construct

4.1 Introduction.

In this chapter, I review contemporary and historical sociological literature focussing on the multifaceted nature of what rural *is*. My investigation explores its construct and how it comes to be, by considering its meaning in the context of space, place and society. Central to this is the agency of the people who inhabit rural spaces. I will explore the social structure of rurality and investigate dominant concepts, theories and inherent tensions that manifest between and within rural and urban spaces. Low and Lawrence-Zuniga's (2004, p.1) perspective that the "spatial dimensions of a culture" gives insight to behaviours and their constructs is incorporated highlighting the relevance of geopolitical and demographic information in understanding rurality. My aim is to provide a clear and lucid understanding of my study area, provide an operational understanding of "rural" whilst accounting for any impact of drug use and associated drug-using influences and behaviours within the context of rurality. I contend the dimensions of space and place must also be given consideration when studying culture. The interplay between culture, society and environment is intricate and inseparable thus it cannot be studied in isolation. Environments, in this context, exert a bio-psycho-social and political impact on actors, which influence and are influenced by their behaviours and activities, including those associated with drug use (Robson 2002), which I consider within a rural context.

The rural context despite its unique challenges and opportunities is routinely overlooked by researchers of heroin studies, which urban-based researchers and policy makers could derive valuable knowledge. Donnermeyer et al. (2013, p.85) assert that rurality offers scholars rich pickings for examining "exclusion, marginalisation and discrimination" by providing a nuanced environment and a contrast to those participant-rich urban settings traditionally visited by researchers of drug use. To comprehend and develop insight into the intricacies of a rural milieu, however, researchers need to be cognisant of rural-specific nuances such as geography, social structures, relationships, and time. Such element not only affect and construct rurality, but they also shape those actors within it, impacting their agency at the same time. My exploration goes beyond a simple geographical or background understanding and definition to encompass the very essence of rural society and culture and those nuanced meanings associated with space and place and the agency of its actors.

4.2 Concepts of space and place.

The conceptualisation of "rural" is developed from its space and place. To understand the essence of rurality, it is necessary to explore the interplay space and place exert in relation to its construct and those who affiliate themselves to it. Defining space and place should be a straightforward process and Massey (1994) writes that space and place are pervasive concepts, deeply embedded in social sciences, a point supported by Urry (2004). Space and place have both been extensively explored from varying perspectives and subject to assorted studies across sociology and wider disciplines. Paradoxically, Low and Lawrence-Zuniga (2004), write that within the realm of social science, space and place are mere "background" considerations and are proffered scant attention. This is because researchers focus on the actors and their agency or phenomena, forgetting the impact and influence of their environment.

Agnew and Livingstone (2011) identified that rurality has not seriously been considered by researchers other than from a geographical perspective, which I consider later. They posit that surprisingly few studies attempt to define space or place from the perspective of their discipline. They argue that within scholarly discourse, however, the utilisation of the terms are frequently and implicitly applied and then unquestioningly accepted in published material. Agnew and Livingstone (2011) contend that a straightforward interpretation of space and place is rendered complex, by the historical and contemporary studies and discourse between different disciplines and perspectives, such as sociology, anthropology, history, geography, and philosophy. These interdisciplinary debates vie to explain, understand, and apply the concepts of space and place whilst also staking a claim to their ownership. Nevertheless, interesting and novel concepts from prominent academics which are apt to evolve over time remain to serve as guiding principles and provocations for researchers. I now turn my attention to the conceptualisation of space, which is notably distinct from place, before giving attention to place, which is notably different from space.

4.2.1 Concepts of Space.

Space is routinely situated by geographers with place, and often set within the context of "spatial dimensions" rather than exploring and examining its autonomous relationship with society a perspective more commonly explored by social scientists. Kesteloop, et al. (2009, p.113) argue this discrepancy is because space is a difficult concept, and it is overlooked by "mainstream sociology" because "sociologists think they can perfectly develop explanations about social facts without taking space into consideration". Spatial dimensions normally

encompass the length, width, height, and depth of a given space which allows a singular (or multiple) position to be identified, providing an exact and precise physical location to be calculated which is a basic requisite for geographers. It is crucial to recognise that the physical location does not define the *meaning* of space or what the space *is*. Shields (2006), states although space can be a clearly defined as a physical area, its geographical delineation proves challenging to define because due to its perpetual state of flux. Space transcends singular physical locations because it can be assigned meaning and purpose and can influence and be influenced by society. Foucault (1967) for instance describes space as heterogeneous, diverse yet ambiguous for those who are within it. He posits that the "relations" that individuals experience within a space create borders and boundaries, tangible or intangible, which subsequently influence the individual and their interactions with others. Foucault contends spaces are not inert; rather they actively participate in the social construct of reality. He identifies and describes these as "utopias" (unreal or imagined spaces) and contrasts them with "heterotopias" (real, meaningful spaces). Foucault argues spaces *are* tangible and *can* be demarcated, challenging the stance that space is either an amorphous or and undefinable concept.

Harvey (2004, p.2) supports Foucault in positing three ontologies of space, identifying space is absolute, relative and relational in its form. He contends space transcends physical location or measurement, constituting "a thing in itself". Absolute space is conceptualised as fixed, asocial, and timeless whereas relative and relational space is socially constructed and continually shaped and reconstructed by ongoing social relations. Relational spaces encompass both new and old dimensions. Older social relations, because they predate the history of the space, retain an ability to exert an independent influence on new social relations as they retain embedded memories associated with the historical context of the space. Thus, space retains an ongoing independent influence upon social relations, distinct from other, sometimes vying, independent influences. The concept of space as relative or relational, i.e., how it is measured, suggests it can never develop an independent function in social relations, because social relations are embedded in space, creating a relative, if not relational space. This would mean each type of social relation has its own geography. Kesteloop et al. (2009) posit that attempting to isolate space from social relations to explore the autonomous function of space or indeed the autonomous role space has in social relations is a futile exercise.

Berry (1967) wrote that space is defined by the interactions that transpire or have transpired within it, i.e., what the land is/was used for, such as industrialisation, population dynamics, or migration, all of which are fluid, rather than being confined a specific set of characteristics. A traditional method of identifying space, he writes, and one that continues to influence contemporary definitions such as rural or urban. However, Smith (1984) challenges Berry's concept, stating that a Marxist view is a more applicable framework to understand space. Space, Smith asserts, is "produced" by financial and economic drivers by those who own the land, be that the "bourgeoisie or peasantry" and it is these actors, influenced by these circumstances, who define space. Thus, Marx would argue there are "rich and poor spaces", whether rural or urban, with those in the rich areas exploiting those in the deprived areas. The rich exploiting the poor, however, happens in all areas according to Lefebvre (2009) and is not a uniquely rural phenomenon.

Douglas (1973) notes that Durkheim (1933) observed that it is society that dominates space, transforming empty space into something meaningful, rendering space identifiable by its structures and social constructs. Low and Lawrence-Zuniga (2004) conceptualise space as a physical environment with social meaning. They explain that space is created through social production, shaped by economics, ideology, and technological factors, and because of the social construction through the lived experience of that space. This extends to the memories, images and "everyday" practices of actors engaged with or in a space. Shields (2006), argues that without the application of Durkheim's theory space is merely universal, physical, and meaningless. Shields (2006) goes on to posit that concepts lead to the application of labels with society inherently attaching labels to voids so they can be claimed and included within their community. Thus, the construct and application of labels helps to categorise, inform and understand space, its purpose and those within it. In contrast, Thrift (2006), offers a nuanced exploration of space using four principles. Firstly, everything is spatially distributed; space has its own geography. Secondly, there are no boundaries to space. Thirdly, space is dynamic and in constant motion. Lastly, there is no one "type" of space: all space is viable.

Tuan (1976) argues that space can be "experiential" and is conditioned by the fact that someone is in it and that space influences and is influenced by the person at the centre of it, such as people who use drugs. Space can thus be defined through everyday activities for instance work, leisure, criminality, deviance, rituals, activities, behaviours, and representations. Tuan (1976) explains that space is a construct of an actor, and it varies with each individual or cultural group

that enters and leaves it. He goes on to note that space may require a person who enters or leaves it to have specific permission or an attribute to do so, whether negative or positive, exclusive or inclusive. A space, in addition, may meet a specific need for an actor, i.e., religious, safety or privacy. Space then can be experienced in a similar or contrasting manner by an individual or group, crucially the experience and interaction leads to the development of the space as place. Sack (1997) cautions that where a person moves too quickly through spaces the notion of place can be quickly lost, to be replaced by a sense of space only. However, Low and Lawrence-Zuniga (2004) contribute that the physical space of a human body exists within a separate entity, an embodied space, and it is this physical entity that constructs a social body.

Massey (1994, p.4) wrote that the conceptualisation of space aligns with the synchronic system of structuralists, which is not independent, but constructed from social relations (social relations are dynamic, thus space is dynamic). Space and social relations have simultaneity and at times multiplicity. She argues that space is therefore symbolic, with inherent meaning that is "constructed out of the multiplicity of social relations across all social scales", which can be observed within towns, workplaces, and households and within social relations. Consequently, space and those within it can be studied as actors' performances both influencing and being influenced by their space, Shields (2006) notes, however, there is no consensus on the absolute nature of space, claiming space is intangible.

Importantly, space exerts an effect on those that live within and outside its perceived borders and boundaries, thereby curtailing or enhancing behaviours. Its structures, populations, functions, and meanings, Shields (2006) argues, define space, but space is never constant, although actors recognise, understand and adapt the space they live within. Low and Lawrence-Zuniga (2004) contend that space is defined by what an actor "states it is", and definitions may be derived from preconceived notions or developed from conscious or subconscious experiences of a space both from those within and those outside the spatial domain.

Space that is labelled and defined also acts to provide parameters for a contrasting space to develop and which may cause or lead to an association or tension. This, Foucault (1967) suggests, can lead to the creation and ultimately binary positioning between dissimilar spaces. The spaces then, not only reinforce their own positions through positive reinforcement but also reinforce their opposing spaces through negative reinforcement. Rurality then becomes what

urban is not and vice-versa reinforcing the dichotomy between them and the views, values and principles of the communities and actors who reside there.

Bourdieu (1993) contends that actors constitute and are constituted by what he terms *habitus.* Bourdieu (1977, p.86) defines *habitus* as “a subjective but not individual system of internalised structures, schemes of perception, conception, and action common to all members of the same group or class”. For actors, habitus is subsequently "deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them” (Wacquant, 2005 p318) assimilating them to the culture, belief systems and values of the communities in which they reside. Rurality transcends a mere physical space; its actors define and are defined by values and behaviours associated with “rural” space. These actors construct the spatial context assigning (stereotypical) values, beliefs and labels to the rural space. The socio-cultural creation then encompasses its physical structures, functions, and society. The resultant constructed narratives do not typically extend to heroin use or associated behaviours, because they do not align with the perceived values associated with rural settings.

4.2.2 Concepts of Place.

The concept of place, distinct from space, can be considered a separate, independent entity, from space despite them both being consistently intertwined. Gieryn (2000, p.463) wrote that like space, place is not routinely considered by sociologists, although they have a “stake in place (and placelessness), no matter what they analyze or how”. I consider dominant sociological concepts relating to place and consider placelessness as I look to locate their concepts and role within the construct of rurality and elucidate its relationship with space.

I begin with Cross (2001, p.2), to define place within a sociological context. She presents it as an “interpretative perspective on the environment and an emotional reaction to the environment” as in “sense” of place. Place then is applied to one’s “place” in the world, but Massey (1994) extends this to a physical place or position, which may be national, regional, or local (localised). She wrote that place could have quite different connotations for different groups such as women, children, or subordinate social classes. Parsa and Torabi (2015) note that people construct their perception of “sense” through two avenues: intimate small-scale geographical spaces, such as their house or workplace, or by large-scale geographical spaces,

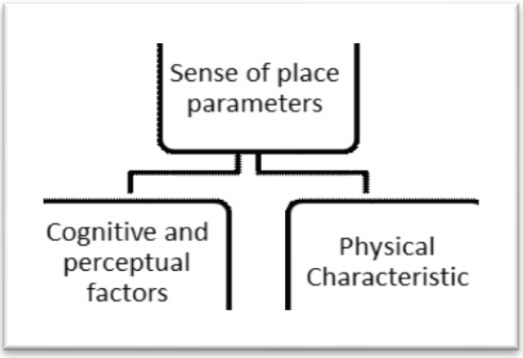
such as their region or country. Additionally, the notion of place can also be conceptualised as a "stasis", which is both inert and slow. Tuan (1976, p.389), however, queries how a geographical location evolves into a place, as he argues there is no systematic analysis to support this transition. He identifies a tendency for people to apply "personality and spirit" to create a sense of place yet accepts these concepts are unmeasurable and difficult to define. Rodman (1992) posits that place is a social construct, shaped by actors' collective understandings and shared assumptions about them. Furthermore, Low and Lawrence-Zuniga (2004) emphasise that actor's structure and experience places based on their personal histories, values, and beliefs.

Cross (2001), however, recognises that people have varying types of relations with a "place", which are apt to change over time. A "place" may range from a favoured spot in a park to a large geographical area, such as a beach. The sense of place may derive from familial ties, specific emotions, cognitive thoughts, materialism, mythical understanding, or ethical choices associated with that location. Tuan (1976) wrote that a place can be considered static, in that actors remember a place as it once was. Conversely, Cross (2001) argues a place may be time-limited, changing as actors forget its significance, age or relocate, rendering a place open to change.

Relph (1976) argues that place was the rational development of space, the next logical step in its evolution. Harrison and Dourish (1996, p.46) concur, defining place as "space with meaning" the meaning as with space, is infinite and inconclusive. Consequently, any space can be labelled as a place and can be identified by an individual or a collective, influenced for instance by perspective or geography. As with space, place is finite, insomuch as time, thoughts and emotions are key to maintaining a sense of place and as they change, develop or decline, so the sense of place changes, evolves or even evaporates. This dynamic can be galvanised in a somewhat poignant manner; any space can be recreated, castles can be rebuilt, battlefields remodelled to meticulous detail, and rooms redesigned to meet precise detail, but they remain spaces until ***meaning*** is attached to them by individuals. Even then, experiences borne from specific spaces at particular times may never be recreated, so the *meaning* that is given to a place by an individual may never be recreated even when space has. This phenomenon is exemplified by the experiences of visitors to rural areas. Their brief encounters with rural "space", may evoke marvel and enthusiasm reinforcing their idyllic notion of rurality, which,

in turn, may reinforce their embedded beliefs (Burchardt, 2015). They may then assign this place with a label, for instance, a “holiday” to identify it in the future.

In defining a sense of the meaning of place, Steele (1981) identifies “sense of place factors”, (image 1) that he understands are pertinent in the process, influencing the attribution of positive or negative meanings ascribed to a place.



Steele (1981). Image 1: Sense of Place Factors.

Steele argues that emotion is derived from the cognitive structure and the perception attached to the place by an individual or group. Simultaneously, the physical characteristics of the place serve as a sensory memory, encompassing its look, feel and smell which combine to create the physical and tangible experience. The meaning of relational (cognitive) space is that space and place are intrinsic parts of our being in the world. This connection is defined and measured in terms of the nature and degree of people’s values, feelings, beliefs, and perceptions about locations, districts, and regions amongst others. The scope of physical characteristics extends beyond place itself to encompass other actors, their agency, and the physical environment. Thus, relational space is consciously and unconsciously embedded in people’s intentions and actions concerning their “sense” of that place.

Tuan (1976) and Stefanovic (1998) both relate the “sense” of place to a value-laden and multidimensional concept, whilst Jorgensen and Stedman (2001) wrote that a “sense” of place broadly consists of three aspects: place attachment (affective component), place dependence (cognitive component), and place identity (conative component). Therefore, as Massey (1994) observed, a single place can have a multitude of meanings to different people, even when the geographical or physical features remain the same. This variation creates quite different places

for different individuals or collectives at different times. Perspectives, Urry (2004) notes, are then developed, and values and labels applied, which may consequently influence the thoughts, feelings and behaviours of the actors and others.

Massey (1994) identifies that a sense of place like space, can be developed before a person physically enters it. Knowledge and values about a place can be gained from other people's perspectives, narratives, values, the media, or their cognitive constructs, leading to preconceived ideas, stereotypes, and beliefs about a place and its inhabitants. Parsa and Torabi (2015) emphasise that a sense of place is distinct from a contrived or preconceived notion, in contrast to space, which becomes widely understood when labelled. Steele (1981) supports this notion asserting that an actor's beliefs are reinforced or altered when they physically engage with a place.

Knox (2005) applied Weberian tradition to examine place, suggesting the "sense of meaning" fits well with the concept of symbolic interactionism. Knox emphasises that both place and space are linked with social construct developed from an actor's social interactions with them, and from which they derive "meaning" and "identity". This understanding extends to objects, events and behaviours concerning and associated with place and space, either reinforcing or rejecting their identity construct. While Gieryn (2000, p.466) cautions that against the application of concepts such as reductionism and determinism in sociological analyses of place, emphasising that a place's "three defining features, location, material form and meaningfulness," should not be hierarchically ranked by researchers. Instead, they should remain equal if credible data are to be extracted.

The construction of space and place would appear to hinge on the geography and assigned meaning attributed to them by individuals or groups. Agnew and Livingstone (2011, p.35) suggest these are general definitions, where space is a fixed physical location where things "just happen" and place is the "geographical construct interposition for processes such as physicality, society and economy". However, these definitions arise from modernist traditions that aim to categorise and label i.e., identities, interests and behaviours Marston, et al. (2005) caution that such definitions are unwarranted because of what Relph (1976) described as "placelessness".

Relph (1976, p.1) defines placelessness, as, "the casual eradication of distinctive places and the making of standardized landscapes that result from an insensitivity to the significance of place". This concept manifests in replicated blueprints of buildings and corporate marketing throughout Britain, meaning spaces are identical and any sense of place is lost. Here we view society's development and reliance upon out-of-town shopping areas, chain stores, coffee shops, local authority housing and "mall" developments replacing idiosyncratic spaces characteristic of 19th-century habitats and 20th-century commerce on the traditional "high street". Low and Lawrence-Zuniga (2004) emphasise that spatial constructs are dependent on actors' influences in applying labels to them, regardless of the place or time of construction.

The advent and popularity of internet shopping, mean people do not need to venture from their place of habitué, as goods and services are delivered to their homes. All the same, this does not stop the labelling of places. This of course may be evolution and the eradication of both space and place as concepts and labels. Thus, the concept of rurality, one could argue, is just as placeless; fields, hills and trees become mere reconstructed blueprints devoid of their original meaning.

Casey (1997) argues there has been an assimilation and fusion of space and place, rendering them inseparable and unidentifiable without each other. He suggests the necessity for developing a new definition that incorporates both concepts. Curry (1998), however, challenges this notion, citing that if specific objects related by society to specific spaces are moved to a space where they are considered foreign, i.e., a tractor and plough driving on an inner-city street, not only do the actors identify the irregularity of the situation but the object also loses its purpose. The tractor and its driver are in the wrong space and out of place, and meanings are then reinforced. Similarly, if we consider a "homeless person using drugs, living on the street and high from a hit" such a scenario may not elicit a second glance from passers-by in an urban setting, but what reaction would there be should that same person be situated outside a rural village shop? Human behaviour, however, demonstrates the capacity to adapt, change and accept that which was once novel and out of place, exemplified by the evolving perceptions of that same person.

4.3 The concept of rurality- Locating "rural".

Rurality has historically and traditionally been cited as an indeterminate and vague concept within the social and other sciences; however, a working definition is required for my

study. In the previous section, I explored the concepts of space and place as a means of clarifying their part in the construct and meaning of rural. Drawing on this discussion I explore empirical sociological research and perspectives from studies focussing on what constitutes rurality by extending this to drug use and people who use drugs within rural settings, I then examine and consider specific challenges or trends associated with people who use drugs in a rural setting.

The term rural derives from the Latin "ruralis," meaning the countryside. The Oxford English Dictionary (2019) defines rural as "relating to or characteristic of the country" with "countryside" being "the rural part or parts of a country or region; the land and scenery of such an area". Geographically, "rural" denotes a less densely populated space, featuring architecture consistent with "fields, farming and agriculture" while the term "country" is indicative of "small settlements outside recognised urbanised areas". Rural structure and architecture may be "man-generated" or natural.

From a sociological perspective, Park (1915, p.582), a prominent sociologist, defined rural as "simpler and more primitive" than cities, where neighbourhoods hold their significance. Massey (1994) suggests rurality can be considered a static, non-urbanised place, where rural space may be given over to a dynamic multiplicity of those that reside within or have an influence on that space at any given time. While rural definitions err towards geography, agriculture or population (Cloke et al. 2006), but both Copp (1972) and Tuan (1976) argue that an environment's essence is less to do with population and more defined by the actors and their agency. They assert this is where *meaning* is derived, and place is constructed through the interactions and influences of individuals in that environment.

Copp (1972), Low and Lawrence-Zuniga (2004) and Donnermeyer (2016) emphasise the significance "*meaning"* given by residents to an environment as being fundamental to shaping its essence. Massey (1994) in citing Said (1993) states "groups" such as rural communities are not natural entities; rather they are manufactured, constructed, and even invented, contingent upon tangible links and a shared "history" with the geography, structures and fellow residents. The construct of the environment relies on the active involvement of people from that setting, presenting these connections and histories. Different environments, however, provide individuals with different challenges and opportunities, as in the case of those using heroin and those seeking to engage in treatment and recovery from it.

Copp (1972) asserts that rurality is shaped by socio-cultural and socioeconomic influences, aligning with the Marxist tradition's viewpoint who posits that financial power and influence in rural society traditionally resides with the gentry and farmers. It is they who construct and influence rural society through their financial control and domination of rural socioeconomics and politics. Examining the impact of space and place on criminal behaviours may be explored and explained through the application of social disorganisation, a place-based concept of criminality. In the early 20th century Park and Burgess (1925) hypothesised that an actor's traits or identity may not be the underlying cause of crime; rather, structural causes within their environment may play a pivotal role. They postulate that an actor's location and residency have agency and play a disproportionate role concerning their criminal behaviour when compared with individual characteristics, for example, their gender, age, or race. Donnermeyer (2016) writes that social disorganisation has its roots within urban areas, but Ceccato (2016) stresses that this does not mean rurality is unaffected by criminality and the positive causes that lead to it. Ceccato (2016) asserts that crime frameworks are biased towards urban centres due to the perception that rural areas have low crime rates. However, Westholm (2008) and Harkness (2020) contend that technology, improved communication, collective community efficacy and lack of anonymity, collectively act to positively mitigate crime and criminality in rural settings.

Skogan (1990) and Ceccato (2016) suggest that urban dwellers often perceive rural areas as safer than urban landscapes, citing the belief that doors can be left open, crime rates are low and organised crime non-existent. They argue that the homogeneity of rural communities contributes to this perception, where "insiders" are known and protected, and "outsiders" distanced until they are either trusted and subsumed into the community or hounded out. There is, as a result, what Barclay (2003) describes as a "cohesion" that serves to control rural areas fostering law-abiding behaviours and minimising criminal activities leading to social organisation dominating social disorganisation.

In consequence, Wells and Weisshet (2004) note that actors from urban habitués often view rural life as idyllic or what Donnermeyer et al. (2013, p.79) refer to as the "rural idyll". Rural areas represent a slower pace of life, green pastures, fresh air, and notably, low crime rates, all considered desirable qualities that may lead people to aspire to "move to the country" (Jansson, 2013). Bell (2006) posits that urban perceptions help define rurality as much as rural populations, topography or geography do. These perceptions are developed and reinforced by

the media and hypermedia, further cemented by populism leading to a contrived and false rural ideology amongst urban dwellers.

Ceccato (2016), however, highlights that rurality can be viewed from very different perspectives, namely, as dangerous and malevolent (Bell, 1997), to be met with disdain, simply because it is not urban (Scott and Biron 2010), or as a place of dread and horror which feels strange (Donnermeyer, et al. 2013). Only those, then, who live the *experience* of rural life can develop emotional connections to create a sense of "place", which extended time spent within rural space brings. de Certeau (1984) candidly argues that actors have ways of generating influences upon space, however, which leads to the creation and re-creation of place, ensuring it is never lost, although he notes it may be altered.

The advent of modernity poses challenges to rural constructs and concepts because of the often-vaunted technological advances that provide immediate global access to communication and internet resources such as goods and social media. This, in tandem with modern infrastructure, including accessible roads, affordable rail and air transport links, means remote communities, which previously took days or weeks to reach, can be accessed in seconds virtually and within hours physically (Parsa and Torabi, 2015). Rural communities are no longer "cut off" from the outside world as the internet provides 24-hour virtual access to communication and commerce. Actors no longer need to travel to settings where shops, for instance, are physically located as material goods can be purchased online and swiftly delivered to a person's home. Commerce in response provides remote communities with 24-hour shopping experiences, including both illicit drugs and drug treatments. In this evolving landscape, urbanity and rurality are no longer the rigid binary concepts they once were, defined and separated by geography, communication links or structuralist parameters. The impact of technology and infrastructure blurs these distinctions and questions the labels of rural and urban.

Nevertheless, space can and remains influenced and reinforced along a temporal axis, as Foucault (1967) noted. Spaces represent heterotopias of time and are both subject to and influence change. Foucault's (1967) important concept, emphasising that time impacts both heterotopias and utopias (for example) as people age. Their perspectives and interactions evolve over time. Furthermore, he muses that the actual space may be given over to specific heterochrony, i.e., libraries and museums are slow spaces, whilst shops and fairgrounds are fast spaces. His concept is often applied in generic terms to urban and rural spaces; the former fast,

the latter slow Foucault argues that this temporal distinction influences actors and their behaviours within (and outside) these spaces, contributing to the construct of an environment. Urban cultures and actors are considered “fast” whereas rural cultures and actors are “slow”. This, Foucault (1984) surmises, constructs time as a concept of urban priority, whereas it is not a primary concern in a rural setting.

Importantly, Lipton (1977, p.23) argues that the difference between the perceived speed of the two environments has been a contributing factor to urban bias, influencing decisions such as “resource allocation, focussing resources on urban priorities” because rurality is “poor” and urban is “rich”, not just in a financial context but in resources, articulation, and power. Donnermeyer, et al. (2013, p.71) however, challenge these points, highlighting criminality, for instance, has “neither a neglected nor underdeveloped interest” in rural spaces.

Foucault (1967) differs, explaining that heterotopia is constant in every culture. Acknowledging it is varied and non-universal nature, Foucault argues it varies in size, and it may be shared with other spaces, or it may be exclusive, it may be static or mobile, defined, or undefined. However, Relph (1991) challenges Foucault’s position on heterotopias, suggesting Foucault’s slow and fast spaces are indeed imagined. Yes, cemeteries are slow spaces; they only change over extended periods; few people visit or stay for long unless deceased. In contrast, coffee houses are fast spaces, speed is essential to meet customer demands. Customers regularly frequent them spending considerable amounts of time there in relative terms. There is also pressure placed upon them by competitors for custom. Relph (1991, p.105) argues that an individual’s perspective on space influences heterotopias and that they are “artificial and marked with deep social inequalities” leading to positive and negative stereotypes and stigmatisation as a result, thus not only influencing the space but those who use or look upon it. Thus, not only an “addict” but a “rural addict”.

Foucault (1967) highlights that heterotopias and utopias are not fixed; they undergo change and continue to change over time, they develop and can be reinvented. What is true of a space now, for instance, may be different from what it was in the past or what it will be in the future, although the physical space may itself stay constant. Thus, space provides only a brief snapshot for would-be researchers and should be revisited regularly as it provides valuable information on the contemporary landscape. Tuan (1976) and Low and Lawrence-Zuniga (2004) agree, emphasising the existence of continuity in aspects of space and place. This continuity could

explain persistent perception of rurality as slow and urbanity as fast, despite the advancements brought about by modernity and developments in infrastructure, transportation, and communication, including social media.

Is rurality then to be confined to a historical concept? Perhaps not yet. Sanderson and Polson (1942), Bertrand, (1958) Desai (2005) argue that rurality is shaped by undefined parameters (although it may have defined boundaries). These parameters are constructed by economic factors e.g., primary employment, environmental factors e.g., land use, building types and use, as well as infrastructure and social structures of the area. The nature of rurality is also influenced by the agency of its population's (e.g., leisure, employment, and health), age and migration to and from the area and the sense of *meaning* (discourse, narratives, memories) derived from these activities that people who reside there have and hold. The concept of rurality may hinge on the "meaning*"* that actors attribute to their own roles and those of others (social interactionism), the environment (structuralism/functionalism) and the agency (everyday, capacity, and embodiment) they exercise within it. Alternatively, it could be based in "realist" ontology (Olsen, 2008).

Rural construct also extends to how those within urbanised areas attribute *meaning* to rurality. Copp (1972) wrote that meaning and labelling of space and place dictate how society constructs, views, interacts and expects rurality to be. He accepts that people coveted the peace and tranquillity associated with rural living, yet migration to urban areas exceeds that to rural areas. This modern phenomenon means urban areas claiming dominance over rural populations, with more than half the world's population now considered urban dwellers. This shift is fundamentally tied to economics factors and, in part, to the draw and expansion of urban structuralism, encompassing cafes, bars, entertainment, shops, and agencies such as healthcare and a higher and more diverse populace. Yet, Douglas (1973) and Bredahl-Petersen (1973) highlight structuralism/functionalism alone cannot fully explain social change. While the influence of distinct functions and structures within rural and urban environments is undeniable, social change does play a significant role in influencing the dynamics of both place and space.

Lefebvre (2003) and Gottdiener, et al. (2014) write that the urbanisation of space commenced with the industrial revolution, triggering a continuous migration flow from rural to urban centres. Consequently, research predominantly focuses on the migration of people and societies

from rural to urban areas, particularly in more populous urban settings. One result has been disciplines such as sociology have replaced their original focus on rural space with that of urban-centric focus, establishing urban as the "norm" and relegating rurality to an unvisited space of contrast for researchers (Lefebvre, 2003).

The notion of what is considered normal is addressed by Kubrin (2009), who defined "norms" as functionalities and dysfunctionalities. Additionally, Donnermeyer et al. (2013) cite Merton (1969) who states that one group's functions may be another group's dysfunctions, all of which hold inherent value. Chari and Corebridge (2008, p.224/5) note the pervasive influence of urban centres stating that "everywhere it is government by the city, from the city, for the city" expressing the *control* urban centres have and exert over rurality, the pull it has over its population and "all that is good within it". This influence, Ceccato (2016) wrote, has resulted in contemporary social scientists displaying an urban bias, with studies within rural settings largely neglected as researchers seek out interesting opportunities within geographically concise urban centres with neatly packaged, numerous, and accessible participants, close to the researcher's abode.

Urban spaces, however, offer a multitude of opportunities for researcher to investigate and understand the influence an environment can exert on actors and their agency. One such study is Parkin's (2013) influential monograph titled, "Habitus and drug using environments". In his study, Parkin conducts interviews with over 70 people who use drugs, investigating and exploring several hundred sites where illicit drugs were administered. His aim was to investigate the utilisation of these specific spaces, the rationale behind their selection, and the impact and influence such spaces exert on people who use drugs and their associated activities and behaviours. Parkin delineates five key concepts; "corporeality, environment, injecting spaces, materials and time" which he asserts should be recognised in any interpretation of behaviours of people who use drugs in public spaces, such as shop doorways, stairwells or public parks. Parkin highlights the impact environments have of on people who use drugs and their impact on their environment in the context of their drug use. These concepts also help shape Parkins analytical framework and provide a robust insight into public drug use in an urban setting. Simultaneously, they proffer a rich vein of data for urban researcher to draw upon and for rural researcher to use as a basis for comparison. Rural settings may be devoid of such environments, with Smith (2014) identifying that her studies participants in rural Wales were wary of administering drugs in public places because of a lack of anonymity.

It is evident from the considerations above that identifying and defining rurality is both easy yet challenging. Although seemingly straightforward, there are no empirically evidenced definitions of "rural" that researchers can confidently replicate. Rurality is, it seems, as multifaceted, intricate and complex as those varied perspectives that contribute to its construct. It is often associated with areas characterised by low and dispersed populations, expansive geographical areas, where time is slower, the environment is given over to agriculture and importantly, is contrasted with urban settings. Rurality, however, is no longer confined to isolation; it is accessible and often intermingles with semi-urban and urban environments, influenced by broader societal factors, and drug use is an integral part of this dynamic. Understanding the consequences of such paradigm shifts require consideration to understand the consequences for rural people and communities.

In my study, I explore multiple perspectives on rurality. I applied the definition of rural that is provided by the Scottish Government (2015), which relies on population statistics to define rural areas. Using the National Records of Scotland (NRS, 2018), the population is categorised into:

(A):

(1) Large Urban Areas - populations of 125,000 or more.

(2) Other Urban Areas - populations of 10,000 to 124,999.

(3) Small Towns - populations of 3,000 to 9,999.

(4) Rural Areas - populations less than 3,000.

(B):

Accessibility based on drive time analysis (based on a complex system for calculating drive times) and accessibility to regions to differentiate between accessible and remote areas in Scotland.

The application of the Scottish Government's definition of "rural and small towns" applies to the area in Scotland I locate potential participants, except for the main town, which is Dumfries, which falls under the "other urban areas". Additionally, I consider the subjective meaning attributed to space and place by the participants who spend their everyday there. It is they who use, apply, and accept the term rural, contributing their own interpretation to it. Finally, I extend my application of rural to include the rural idyll, its geography, structures, and function,

elements commonly associated with everyday expectation, terminology and labels which pervade society and are commonly associated with rural settings. While there exist both differences and similarities between rurality and urbanity, the application of the parameters commonly applied to define and assert rurality, in conjunction with those applied to assert urban areas, supports and underpins the assertion of Dumfries and Galloway being "rural".

4.4 Rural drug use and drug use trends.

Studies on rural drug use and drug use trends are limited, specifically those focussing on people who actively use drugs in rural settings. Researchers predominantly concentrate on urban and inner-city environments as they provide easier and more convenient access to higher numbers of participants within confined geographical areas (Scottish Government 2008; Heil, et al. 2008; Best 2010; ISD 2015). As a result, drug-related research centres almost exclusively on urban drug use, with Schoeneberger et al. (2004) and Heil, et al. (2008) arguing resulting data are dominant and consequently inform policies with an inherent urban bias. These policies, inadvertently applied to all geographic areas, potentially disadvantage rural people who use drugs. The influence rural Dumfries and Galloway has on people who actively use drugs, as well as their drug use and recovery remains uncertain. Similarly, little is known about how people who use heroin influence the rural spaces in which they live. Despite these uncertainties, there is empirical evidence that can be drawn upon which explores rural drug trends. I begin by exploring evidence that explains how drug researchers define rurality as they locate their studies.

4.4.1 Rural drug use research.

Researchers examining drug use in rural communities, such as Keene, et al. (1993, p.1064), who conducted a study in one of the "most rural parts of the U.K.," and Barnard and Forsyth (1998) and Meysamie, et al. (2009), who also cite "rural" in their research, surprisingly do not offer a clear definition or specifications for what constitutes rural within their studies. Readers are left to interpret rurality based on their own understanding, which leads to assumption and arguably uncertainty. However, it is plausible that constructing and defining rurality in drug use research is more complex than initially perceived.

In sociological research, specifically on drug use, authors such as Brown, et al. (1977) define rurality predominantly using statistical parameters. Their admitted "arbitrary", statistical parameters for rurality set a population threshold of fewer than 25,000 people, and urban

threshold populations of 500,000 plus; notably the 475,000 people in between were not categorised. Carman (1979, p.17) offers a differing perspective, writing that rurality is a "population of fewer than 11,000 people," while Aluned and Hussain (1984) identify a population density of "20-24 people per square mile" (11 people per hectares) as rural. Cronk and Servela (1997) and Ahmed and Yusuf (2004) assert rurality equates to a population of fewer than 50,000 people, with Gfroerer, et al. (2007) citing less than 20,000.

Expanding on rural parameters, Heil, et al. (2008) identified a town with a population of 39,000 people, while Schoeneberger, et al. (2004), established two categories, "very rural" for areas below 2,500 people and "rural" for populations between 2,500-50,000 people. By contrast, other authors omitted population statistics and concentrated on structural aspects. Barnard and Forsyth (1998, p.423) define rural as "agricultural villages, hamlets and isolated farms" and Ardery and Bishop (2006) characterised it as "non-metropolitan". Furthermore, Ettingler (2004), Putt and Delahunty (2006), Paulozzi and Yongli (2008), Meysamie, et al. (2009), Young, et al. (2010) and Keuhn (2014) did not define or indicate what they meant by rural at all in their studies. Lenardson, et al. (2016) clarified that many authors acknowledge the ambiguity surrounding a clear definition of "rural," particularly in research on drug use in rural settings with populations ranging between 20,000 and 50,000 people in the U.K. and beyond were included as rural.

Edwards (1997, p.79) identifies one of the key issues with rurality: the conceptualisation "what is and what is not rural". As Copp (1972) explains, rural sociology faced a "knowledge gap" in the 1970s compared with the 1940s. Sociologists were either unable to acquire funding to study these areas or preferred to study cultures in exotic lands or urban venues, ignoring rural settings in close vicinity, creating this knowledge gap. It is a gap this study intends to address. Massey (1994) and Shucksmith and Brown (2016) note there have always been spatial inequalities between urban and rural areas, a bias toward the urban to the detriment of rural environments. Massey (1994, p.51) continues that such inequalities are "historically relative", but they do change as time passes, emphasising the need for ongoing research to identify changes and trends in rural settings, for example drug use, associated treatments and the application and evaluation of targeted strategies. The focus of rural drug use is almost entirely equated with population density, to the exclusion of, for example individuals' everyday life, transport, housing, or community. This oversight leaves uncertainty regarding the construct of people who use drugs within a rural setting. So, what are the grounding assumptions and

knowledge about rural drug use (and people who use drugs) in social research and where do its ontological roots lie in neo-liberal society?

4.4.2 Rural drug research.

Exploring historical and contemporary empirical evidence on rural drug use reveals, as I have previously mentioned, a surprising dearth of literature, whereas the corpus on urban studies is extensive. Barnard and Forsyth (1998, p.422) affirm that research into rural drug use has been "at best patchy and disparate", a sentiment supported by Ahmed and Yusuf (2004). Gfroerer, et al. (2007, p.10), argue that their study into 900 people who use drugs in the rural U.S. under the age of 25, identified a need for specific research and data derived from rural settings as being "critical". Evidence supports the assertion of rural drug use being problematic. Brown, et al. (1977, p.23) found that the 1970s statistics on people who used heroin in rural U.S. were conservative estimates, and those statistics did not reflect the actual "high numbers of people who use drugs and use in rural environments." Their evidence indicated substantial intravenous drug use in rural U.S., where individuals reported a higher, if infrequent, use of heroin due to its sporadic supply. They supported their argument by identifying that drug-related crime was not congruent with statistical data at that time. They identified high levels of burglary and shoplifting (which they both cite as synonymous with drug use) in rurality as proof that drug use was more prevalent in rural U.S. than reflected in national statistics. Why else would people commit such crimes? Achieving anonymity and hiding deviant behaviour in rurality, however, is challenging. The resale of illicit goods is more complicated within the area and the risk of arrest and prosecution is arguably, greater than in urban settings. A lack of anonymity in rural settings means that identifying perpetrators and tracing the origins of stolen goods, makes these crimes less appealing to people who use drugs in a rural setting, a finding reflected in my study.

In the period spanning 1976-1997, Cronk and Servela (1997) and later Ardery and Bishop (2006) noted a decline in drug use in rural U.S. The reasons for the decline were unclear but could be due to reduced drug use or lack of research into rural drug use during that time. Ardery and Bishop (2006), however, identify a steady increase in rural drug use since 1997, coinciding with *OxyContin* release in the U.S., though not reaching the same level as the mid-1970s. Cronk and Servela's (1997) study of 100 urban and 100 rural people who used drugs, found lower numbers of people who self-reported a substance use disorder in rural areas compared to urban

settings. However, recent data form the Centers for Disease Control and Prevention (2017) indicate that rural drug use has not only caught up but surpassed urban drug use.

Several noteworthy British ethnographies focus on rural drug use, for example Smith's (2014) study involving twenty women who were actively engaged in drug use from rural North Wales. Smith investigates their hidden everyday lives, as she attempts to capture their subjective experiences aiming to understand these women's lives within both rural and drug use contexts. Smith's research explores what significance drug use has in their daily lives, examining how gender performativity and spatiality influence their risk behaviour. Her findings emphasise the importance of understanding and investigating gender and place dynamics in the development of effective intervention strategies, highlighting the enduring relevance of traditional gender roles within a context of contemporary rural life.

Smith's (2014) study highlights the intricate role gender performativity and rural spatiality has on shaping and constructing risk behaviour among women who have intravenous drug use experience in a rural setting. Her study highlight's role conflicts women experience navigating their "intravenous drug use" careers and their expected conventional gender roles for instance as mothers and partners. Smith found that her rural participants "lives and options have been constrained, not only by their drug use, but also, in the majority of cases, by poverty and economic hardship, social marginalisation and violence" (p522) linked to their environment. Participants drug use trajectories were found to be structured by these multifaceted influences shaping the way women attributed meaning to and experienced their "IDU careers." My own data also finds a strong attachment to (rural) place which women (and men) do not want to leave, making them susceptible to the allure and continued use of illicit drugs, reflecting Smiths findings. The performance of femininity by Smiths participants locates them within a socio-historical construction in their sense of self and belonging to their rural place, which for the women was the private sphere of their home. Notably, drug use was not routinely conducted within their homes or in isolation as they preferred to administer drugs in neutral spaces such as communal indoor rooms when administering drugs. Smith (2014, p523) recognises several shared contributing factors amongst her participants that arguably limit their life choices, including drug use, poverty, economic hardship, social marginalisation and violence. These factors perpetuate their involvement in drug use whilst they also navigate the many complexities of managing multiple roles and relationships while

they continue to pursue their drug careers. Their inability to resolve these challenges is based in their strong attachment and association to their specific place.

Parkin (2013) offers a thought-provoking scholarly perspective on the intricate interconnections between health outcomes and spatial environments used by people who use drugs for their drug administration (health-place nexus concept). In his study, Parkin explored and investigated the impact physical settings, such as car parks, stairwells, doorways, public lavatories and abandoned buildings have on shaping health outcomes and individual experiences of drug use. He draws on interviews conducted with people who use drugs, health practitioners from that field, and over 400 observations and assessments appraising urban environments where drug use transpired. Parkin categorises these environments as "public spaces", akin to Smith's (2014) "neutral" spaces, places ostensibly "hidden" yet paradoxically conspicuous to the public.

Parkin argues that these environments play a role in the production, reproduction and amplification of established harms and hazards associated with drug use. These include sharing equipment, transmission of HIV/HCV, unhygienic preparation and areas, involvement with the criminal justice system and instances of violence. In contrast, public (neutral) spaces were rarely, if ever, used by my participant's. The reason for which could be attributed to several factors that underpinned a necessity to use such physical environments in Parkin's findings, such as an urgency to use drugs, not being homed, inexperience of drug use or anonymity. Such nuances highlight a complex intersection that lies between behaviours associated with substance use disorders and spatial environments and the impact they have on individuals and those environmental influences that then shape health outcomes in the context of substance use.

Participants in my study for instance, routinely reported stable and secure housing and that homelessness was not problematic for people who used heroin within the region. Roe, et al. (2010) writes that stable accommodation reinforces safer drug-using behaviours for the individual and wider community, thus enhancing recovery through "recovery capital." People who used heroin in my study explained their homes were safe and private environments with the prerequisite paraphernalia (needles, syringes, sharps boxes, provided free from the SDAS and pharmacies) close to hand. Whereas Parkin (2013, p10) noted shared environments for

drug use could lead to “harmful poly-drug use, police raids, unsanitary conditions…lacking basic amenities, all of which impinge safer injecting practices”. Parkin’s focus was on established spaces for drug use in urban areas, where he contemplated the dynamics of the “presence/absence of a particular form of innovative harm reduction” (p11) consumption rooms. These had demonstrated positive results in the mitigation of risk in street-based drug use in other countries. A consumption room is due to open in Glasgow in 2024 in response to the drug related death crisis in Scotland. However, the applicability and benefits of this harm reduction model to recovery pathways in rural settings is uncertain, due to the geography and transport challenges commonly faced in rural settings.

In the U.S., the increase in rural drug use has been related to methamphetamine production and the use of over-the-counter opiate-based prescription analgesia (such as OxyContin and Fentanyl) within the rural U.S. Young and Havens (2011) and Keuhn (2014), report that contemporary people who use heroin in the U.S. regularly identify over-the-counter prescription medication as their “gateway” drug to heroin. Participants, Keuhn (2014) explains, switch to heroin (when prescribing doctors limit or stop prescriptions), for its increased potency and lower cost than pharmacy purchased prescriptions. This contrasts with Stallwitz and Shewan’s (2004) qualitative research study of 12 people who use heroin in the Shetland Islands, Scotland. The study reported that people who use heroin in that setting found it difficult to access and become dependent upon heroin, due to its sporadic availability in rurality, thereby reinforcing the continued use of OTC opioids. Incidentally, reports of heroin use have not followed similar upward trajectories within the U.S. casting doubt on the assertions made by Young and Havens (2011) and Kuehn (2014).

Putt and Delahunty (2006) and Gfroerer, et al. (2007), however, found heroin to be the least used drug in rural areas (a recurring theme across studies) due to its sporadic supply. In contrast, they reported, that cannabis was the most used drug in both rural and urban settings, due to its perceived low risk and availability. Cicero, et al. (2014), using data from a U.S. national sample of three thousand people engaged in drug treatment programmes, found that heroin, typically injected by the person who uses drugs, remains the opioid of choice where supplies are consistent. Despite assertions regarding heroin availability and use within rurality, Young, et al.’s (2010) study based within the Appalachians found twice the number of rural participants (96% white, av. age 33), reported lifetime heroin use compared to people who use drugs in an

urban setting (11% white, av. Age 42). Ardery and Bishop, (2006) notes such statistics may be due to poor comprehension of the potential risks of heroin use in rural areas, meaning it goes unreported, or, as Stallwitz and Shewan (2004) write, due to a more liberal and tolerant attitude within rural society.

Barnard and Forsyth (1998) cite the low availability of heroin in rural areas as being a reason that may drive and necessitate the acquisition and use of any available drug, contributing to the prevalence of drug "cocktails" (poly-substance use) and OTC opioids in rural settings. Putt and Delahunty (2006), however, recorded those Indigenous rural people who use drugs in Australia were not inclined toward "poly-substance" use as their urban counterparts (except for cannabis). They noted alcohol as the most frequently consumed psychoactive drug because of its reliable availability, legality, and low cost. These points may reinforce OTC opioid use in rural U.S.

Barnard and Forsyth (1998) also found that although heroin is the second most known drug (after cannabis) it is the least "offered drug" in rural Scotland, the reasons for which were unclear in their study. The discrepancy may simply be because of a lack of research into people who use heroin in rural parts of Scotland. However, both Gfroerer, et al. (2007) and Lenardson, et al. (2016) commented that people who use drugs in a rural setting were less likely to perceive heroin use as a "risk behaviour" (i.e., "addiction", overdose) compared to their urban counterparts, making them less inclined to seek or receive treatment for their drug use. This is reflected in drug use statistics and may impact drug treatment and recovery resources within rural settings, where the perceived need is diminished.

Paulozzi and Yongli (2008) crucially note that rural drug use is becoming increasingly problematic following their research into drug poisoning mortality rates within the U.S. Worryingly, Young, et al.'s (2010) study of 212 white urban and rural (n101) participants who used opiates, found that illicit prescription opiate use (OTC/prescription medication) in rural U.S. has quadrupled since 1990, while urban use had remained stable. Musculoskeletal pain often associated with manual labour and chronic pain related to rural employment may initially drive individuals to seek opiate-based analgesia from medical doctors. Additionally, there was also an aggressive marketing strategy by Purdue Pharma, the developer of OxyContin in 1996, coincides with the reported drug rise in drug use within rural U.S., with its sales peaking at $1.1 billion by 2000, up from $48 million in 1996 (Van Zee, 2009).

Over the past eight years, drug poisoning (overdose) has seen an increase in rural areas, indicating a possible rise in rural drug use or a shift in drug associated behaviours. This rise is being linked to prescription opioids (methadone), over the counter (OTC) analgesia, low-cost (counterfeit, "street") benzodiazepines, and cocaine, with some increasing by 250% in some rural areas in the U.K. and U.S. Notably, deaths linked solely to heroin use remained largely unchanged (The Office for National Statistics, 2022; The National Records of Scotland, 2022; Centers for Disease Control and Prevention, 2022).

Poly-substance and alcohol use, according to Dumfries SDAS in 2019, were the primary contributing factors to increased drug-related deaths in Dumfries and Galloway. The SDAS highlight a notable change in drug use trends and patterns over the past decade, with people who use drugs very rarely reporting exclusive heroin use in contemporary clinical practice. This shift in drug-associated behaviour over the past eight years aligns with an increase in drug-related deaths during the same period. Heroin use in the area, the SDAS report, is predominantly confined to an older demographic (35-40 years and old), whereas younger and newer people who use drugs commonly engage in "cocktails" comprising cocaine, benzodiazepines, and alcohol whilst actively rejecting heroin. Notably, there is no formal research into the region's drug-using population or their associated drug-related behaviours.

The reasons behind the increase in rural drug use remain unclear. Carman (1979, p.91) found the primary motivation for drug use in rural areas was not solely socio-economic, but also stemmed from the "personal effect" that drugs induce. In this respect, the motivations were no different to people who used drugs from urban settings, i.e., changing moods, emotions, and supplanting memories, as well as easing social interactions. Carmen's findings also suggest the rural idyll lends itself to calm contemplation and relaxation rather than increased drug use. Migration patterns, the increasing use of drugs among rural inhabitants (increased availability, lower cost), the increasing engagement with treatment services (increased service accessibility) and an increasingly effective criminal justice system, could all be influential in the increase of drug use. Lenardson, et al. (2016), Terry and Cardwell (2015) and Robertson (1997) found that rural communities are susceptible to socio-economic vulnerabilities such as low income, unemployment, poverty, along with physical and mental health issues. These factors are identified as significant causative factors to the initiation and perpetuation of drug use in rural

settings. Of course, it is worthy of note that drug use may have always been embedded but undiscovered within rural settings.

Keuhn (2014) states contemporary drug use now spans all environments, encompassing both urban and rural settings, with statistics reflecting similar level of drug use in both contexts. Keuhn states, as Cronk and Servela (1997) argued over twenty years earlier, that the concept that drug use was solely an urban phenomenon no longer withstands scrutiny. However, the question arises: What characterises a rural individual who uses drugs?

4.4.3 Rural construct of people who use drugs.

It is important to acknowledge that much of the research into rural drug use centres mainly on the rural U.S., where 20% (60 million) of the population reside in rural settings. Studies are contemporary with the focus on drug use amongst inhabitants connected to the Appalachians Mountain range (population twenty-six million, mean age 41 years old) that straddles thirteen states and spans 206,000 square miles within the U.S. Communities there are physically accessible to "outsiders" but may take days to travel to and are characterised by economic challenges, associated with declining employment opportunities, and sporadic, low-income jobs such as agriculture and mining. Cloud, et al. (2019, p.49) articulate that there is:

> "A barren job market diminished formal opportunities for social enrichment, and stigma were macro-level features of the social and economic environment that shaped drug use among young adults".

People within the Appalachians routinely cultivate and sell marijuana and distil and distribute illicit alcohol. Prevailing drug research, however, predominantly centres upon methamphetamine use, primarily its production and the use of prescription opioid analgesics such as *OxyContin* and *Fentanyl*. The focus on this demographic is notable; with drug use (and consequently research) reportedly most prevalent among white, working-class men. The high numbers of existing research studies as highlighted by Young, et al. (2010) and Ardery and Bishop (2006), explains the prevailing image of rural people who use drugs in the U.S. are routinely portrayed as poorly educated, white men in their thirties with lower income expectations. Such portrayals identify further challenges in recovery, citing prohibitive treatment costs and limited life opportunities. It is crucial to acknowledge the potential bias stemming from this homogenous group, as the numerous studies that there are focusing on this

demographic may consequently influence and shape global perceptions, trends and discourse on rural drug use and people who use drugs. This phenomenon essentially leads to reification of drug use and those people who use drugs implying an assumed objective and decontextualized reality of their lives and experiences (Einstein, 1983, Klaue 1999).

Drug researchers are directing their attention toward the Appalachian community, (84% white and 7% Black) as they are affected by a "substance use disorder crisis" (Appalachian Regional Commission, (ARC) 2019, p.1). This crisis has resulted in a 43% higher to overdose mortality rate in Appalachian men aged 25-54 years old (mean age 39) in comparison with other regions of the U.S. This statistic has led to intense media coverage and societal scrutiny across the U.S. The ARC (2020) cites alcohol misuse (30%) and opioid overdose (70%) (Coinciding with a rise in prescription opioid drug use since 1996) as the root causes of overdose. Access to healthcare including drug recovery treatments is often prohibitive in the U.S. due to excessive costs, with many impoverished citizens, such as the Appalachians, unable to afford adequate if any healthcare insurance (Adler, 2012).

Studies emanating from the rural Appalachians are innumerable and ongoing and include Leukefeld et al. (2007, p.504) whose study cites the increased reports of prescription OxyContin in drug treatment programmes. They explored 70 (99% white, 67% male) key informants' perceptions of opioid prescription use and found 41% of "treatment admissions were related to OxyContin". These key informants confirmed that prescription opioid use was problematic and long-standing within the rural Appalachian community. Notably the study did not directly involve people who use drugs; instead, it captured perspectives, opinions, and interpretations from non-opioid using professionals.

Young and Havens' (2011) cross-sectional comparison of 503 people who use drugs in rural Appalachia similarly report a highly homogenous group (94% white, 57% men, Av age 32). These participants, self-reported as people who actively used drugs such as prescription opioids, cocaine, methamphetamine, and heroin. This group was representative of the population insomuch as they reported low rates of education (56% completing high school) and high rates of unemployment (57%) and criminal activity (65% reported imprisonment). Young and Havens (2011, p.589) stated:

> "Of the 394 IDUs, 48% initiated injection with OxyContin®, 30% with stimulants (4 methamphetamines and 117 cocaine) and approximately 14% initiated with other prescription opioids, (85%) IDUs began injecting after 1995 (the year OxyContin® entered the market)".

Other studies (many of which used cash incentives to encourage participants), on rural drug use emanating from the U.S. such as Leukefeld, et al. (2007), Jonas, et al. (2012), Havens et al. (2013), Cloud, et al. (2019), report similar drug-related challenges within their participant samples, representative of their study area's demographics. Despite drug use in rurality being problematised, there remains a clear focus on research from a homogenous and limited demographic pool from rural U.S. Appalachian drug-using communities. Data, albeit unintentionally, reinforces the perception of the constructs of people who use drugs in rural settings are white, poorly educated, and impoverished men in their thirties who use alcohol and prescription opioid analgesia to counter their chronic pain and limited life opportunities. However, this representation may not accurately reflect people who use drugs in rural settings or rural drug use. There is a critical need for research from wider rural communities, such as those in Scotland, to redress the existing imbalance in rural drug research and discourse. To address these specific issues and trends in relation to drug use, there is a need for research into the identities, activities and behaviours of people who use drugs in a broad range of rural settings. This diverse data would inform and instruct appropriate resource allocation, strategies, treatments, and interventions tailored specifically toward people who use drugs within rural settings.

4.5 Socio-economic characteristics of rural Scotland.

Understanding the socio-economic characteristics of rural Scotland assists in aligning these rural communities with common causative factors associated with drug use. Despite Scotland experiencing lower poverty rates per capita in comparison with the rest of the U.K. and reporting broadly similar unemployment and mental health issues (table 1), Scotland has a higher reported rate of heroin dependency. While the demographics of Scotland and the rest of the U.K. broadly align and drug use in Scotland has stabilised over the past two decades Scotland reports a four times higher rate of heroin use. Crucially, statistics on drug use are traditionally based on "estimates," given the lack of formal methods for accurate assessment, particularly for drugs such as heroin. Evaluation relies on self-reporting, toxicology-related deaths, or through the criminal justice system.

	Poverty	Unemployment	Mental health issues	Average wage	Heroin use
Scotland	18% (1 million)	6.1% (170,000)	25% (1.3 million)	£27K	1% (60,000)
Dumfries	13% (18,500)	5.4% (2,000)	25% (36,000)	£17K	1.5% (2,200)
Glasgow	21% (120,000)	9% (28,000)	25% (150,000)	£20K	2.79% (16,740)
R.U.K.	21% (12 million)	5.4% (3 million)	25% (14 million)	£27K	0.5% (300,000)

(Table 1) Scottish demographics: Office for National Statistics (2015), ISD (2015), Scottish Government (2015).

Concerning the criminal justice system, criminality is not exclusive to urban areas. Ceccato (2016) argues that rural settings exhibit specific forms of criminality, shaped by the unique characteristics of rural actors and rural settings. Clinard (1952) explains that rural environments possess their own distinct criminal dynamics due to close-knit communities and a lack of anonymity. He argues that this environment deters criminal behaviour, whilst simultaneously embellishing informal control by the local community and law enforcement officers. In comparison to urban settings, rurality has different predictors of crime. Ceccato (2016) and Osgood and Chambers (2003) highlight low crime predictors such as, low growth rate, homogeneity, wealth, social capital, family structure and low transiency. Jobes, et al. (2004) and Kaylen and Pridemore (2013) also found that poverty and transiency (positively indicated in urban criminality) were not positively correlated with rural criminality.

White (2011) highlights that rural criminality, frequently associated with social disorganisation, centres mostly on environmental and wildlife crime. Additionally, Donnermeyer, et al. (2013) detail rural capitalistic crime committed by wealthy landowners, such as worker exploitation and harm, as well as criminal behaviour associated with immoral practices such as animal cruelty and farm-derived pollution. However, Lefebvre (2003) argues that rural crime is often compared unfavourably to urban crime statistics, and the urban "ideals" of what constitutes rurality tend to downplay any significance of rural crime. Consequently, rural crime is not considered to be as serious in comparison with urban criminality. The effect this has is to diminish the impact of rural crime, limiting its impact, influence and recognition on urban actors. In addition, criminality linked to rural drug use is routinely underreported,

downplayed, underrepresented and overshadowed by criminality linked to drug-use in urban settings.

4.6 Chapter Conclusion.

Rurality transcends geographical topography, urban contrast, boundary setting, and population statistics. Within modernity, infrastructure and technology render rurality as just as accessible as urbanity and challenges positivist signposts traditionally employed to construct it. Rurality can arguably be perceived as a subjective concept of space and place, shaped by the nuances and impact by the people who inhabit it. It is further defined by the centralisation of socio-political administration in urban centres, from where power cascades down to large towns, towns, villages, and hamlets. The significance lies in the perspective of what defines, distinguishes and separates rurality and urbanity which is dependent on actors and their interpretations. The more rural the actor for instance, the more urban built-up spaces seem, thus even small towns can be considered "urban" to someone who lives on a remote farm whereas a simple expanse of green land may be considered rural to an urban dweller. In 1976, Tuan asserted that human experience is essential in defining rurality. However, contemporary sociological studies and discourse often draw upon positivist definitions when defining and categorising space, place and their inhabitants based on predefined criteria. It is crucial to recognise that the "meaning" and "essence" of rurality emanates from those people who live there. It is inhabitants that shape rurality into a dynamic concept, challenging rigid positivist categorisations and static classifications drawing on their diverse experiences, perspectives and interactions with the realm of rural spatiality. Nevertheless, DeKeseredy et al. (2007), assert that efforts to classify rurality are mostly met with criticism because they arguably are considered to hold the power to generate stereotypical representations of rural homogeneity.

Agnew and Livingstone (2011) highlight space and place exhibit multi-dimensions, representing a multiplicity of locations and settings, but where everyday life unfolds. This dynamic interplay leads to a sense of place or identification, which is defined and shaped by those social interactions. This echoes Relph's (1976) foresight that space and place may no longer be defined or isolated; instead, they are seamless and dynamic. Actor networks, topologies, and migration all contribute to this fluid definition and shaping space and place on a local, national, and global scale. It is rural inhabitants who actively give *meaning* to their space and place simultaneously defining themselves and by exploring and studying how they engage with their rural environment, considering structures, resources, activities, relationships

and their inherent commodities such as transportation, and employment, data can be collected and analysed to comprehend the intricate relationship between, space, place and people who use heroin. This exploration prevails in defining what part space and place play in the construct of rurality, particularly the lives of people who use heroin within a rural setting, (Alexander, 1982) and elucidates the influence and impact their activities and behaviours have on rural space and place.

Everyday lives of people who live in rural settings are influenced by rural spatiality, shaping their experiences in response. However, defining rural space and place often errs toward abstract typologies rather than representing the richness and essence of rural lived experience. This conceptualisation subsequently informs, shapes, influences, and defines rural space and place including its inhabitants and outsiders. The common notion of rurality often conjures images of idyllic living, open fields, lush forests, farming, fresh air, and a simpler, slower pace of life within safe close-knit communities.

Rural spaces, however, are not immune to criminality, deviance and drug use. Nevertheless, there a dearth of research and analysis on these aspects of rural life and the implications of drug use on rural communities. Existing studies as identified are primarily drawn from the U.S. focussing on over-the-counter prescription opiate medications, methamphetamine, and alcohol use drawn from homogenous groups. The resultant data forms the foundation and underpins the construct for the identity of rural people who use drugs. Little remains known about the everyday lives, recovery, or re-integration of people who use heroin in rural Scottish communities. Regardless, drug policies and strategies, such as the Scottish Government's *The Road to Recovery* (2008), were uniformly implemented in urban and rural settings, ignoring any unique challenges and opportunities faced by rural people who use heroin. Tucker (2015, p.11) concisely explains that the understanding of rural deviance frequently succumbs to "global explanations," predominately relying on data drawn from urban-centric studies. Rural voices and lives, however, are important and Tuan (1976, p.422), who quotes Socrates in asserting that "the unexamined life is not worth living" irrespective of how or where it is lived. In the next chapter, I explore my methodology, explaining how and why I conducted my research, along with the practical methods employed to collect and analyse the data.

Chapter 5: Methodology

5.1 Introduction.

In Chapter 1, I outlined my research aim and objectives. In brief, I aim to explore and understand heroin use and what recovery means to people who actively use heroin, within the rural setting of Dumfries and Galloway, within the context of the Scottish Drugs Policy; "*The Road to Recovery"* (2008-2018) (Scottish Government, 2008).

Research objectives I consider in connection to the aim are:

1. To investigate how people who use heroin in rural areas acquire, administer, and fund their heroin use (chapter 6).
2. To investigate the use of heroin in the context of "everyday life" in a rural setting (chapter 7).
3. To explore what meaning recovery holds for people who use heroin in a rural setting (chapter 8).

I employed an ethnographic interpretivist approach to investigate my research aim and corresponding objectives. In this chapter, I detail and describe the rationale for this approach and why it was suitable for my study. I will explain that using ethnography allowed me to develop a deep, rich vein of original data using interviews, field notes, participant-observation and nonparticipant observation, (Hammersley and Atkinson, 2007; Whitehead, 2005; Wolcott, 1987) and that an ethnographic approach facilitates interactions between researcher and participants within their "normal" habitat, even where they are hard to reach communities. Ethnography enables the "everyday" to be explored through immersion into the participant's worlds and lived realities. Having introduced and justified my approach I describe the complex ethical considerations of the research before detailing my fieldwork and data collection pathways, including participant selection and engagement. I go on to describe my approach to my data analysis and conclude the chapter with a discussion and consideration of the strengths and weaknesses to my approach.

Applying ethnographic methodology, I investigated the daily practices and behaviours of people who use heroin within a rural context, against the backdrop of a public health crisis characterised by associated harm indicators such as drug-related fatalities in Scotland. My

research focused on rural Dumfries and Galloway, which to the best of my knowledge has not previously been explored. Employing a rigorous but reflective approach, my ethnographic study yielded novel insights into their lives. By delving into the intricacies of their everyday practices and related mundane activities, my work offers a fresh and nuanced perspective.

5.2 Methodological considerations.

I considered various research designs to identify a suitable methodology to meet the aim and objectives of my study. I rejected quantitative methods because they are not suited to exploring the lived experience of participants (Hammersley and Atkinson, 2007). Authors such as Kaplan and Verbraeck (2001) also note quantitative methods, steeped in their positivist traditions, do not allow for the sort of personal interactions needed to identify feelings, emotions, and the intricacies of the everyday lives and practices of people. This sentiment is echoed by Martin and Stenner (2004, p.395) particularly in studies pertaining to drug use, where they consider, "quantitative methods to be too narrow and too reductionist." To effectively meet my research objectives, I required a paradigm that afforded me the means and opportunity to learn about their culture and explore their social interactions. This meant employing qualitative methods, because as Cormack (2000), Rhodes and Moore (2001) and Punch (2005) state, qualitative research enhances the collection and analysis of data about the perceptions, meanings, beliefs, values, and attitudes of participants within their environments. Finlay (2000) adds that qualitative methods assist in investigating phenomena in an in-depth and holistic manner through the gathering of observational, verbal, pictorial, and written information. Cresswell (2009) also points out that a qualitative method allows the researcher to tap into the thoughts, beliefs, and feelings of actors providing a framework to explore participants' everyday life and present an insight into their worlds and lived realities.

Qualitative methods have a long and proven tradition within social sciences, but their use is nuanced and by no means straightforward. Brewer (2000) posits they can potentially stifle researchers' creativity if applied in a formulaic manner. Maggs-Rapport (2001) also noted that qualitative methodology serves only to explore past experiences and thoughts, not the present or future, as participants construct their world through "verbal expression." Having decided on a qualitative approach because it fulfils the conceptual framework of my aims, I considered which approaches to use, taking into consideration the dominant approaches already applied by scholars who study people who use drugs which are phenomenology, grounded theory, action research and ethnography.

Phenomenology, grounded theory and action research are well established and evaluated and as methodologies incorporate different methods that can apply to a range of data collection and analysis methods. Phenomenology, for instance, typically employs in-depth interviews to investigate how participants consciously experience their world, without theories about their causal explanation and as unencumbered as possible from unexamined preconceptions and presuppositions (Hycner, 1985; Groenewald, 2004; Flick 2014). It is, however, imperative to acknowledge the inherent limitations phenomenology has. Glaser, (1992) Dawson, (2009) and Van Maanen, (2014) note that it does not allow researchers access to the environment of the actor meaning potentially valuable information is missed concerning actor agency, environments, and social interactions. Grounded theory, as a methodological approach, also primarily relies upon interviews to explore perceptions, experiences and hypotheses construction pertaining to relationships. This methodological orientation Glaser, (1992) and Walker and Myrick, (2006) found errs toward objectification of data. Grounded theory, then, is concerned with discerning relationships and patterns inherent within the data, subsequently developing a conceptual framework that explains the social phenomenon under consideration. Its emphasis focusses on drawing theoretical insights directly from data, which allows the construction of a robust explanatory framework which is grounded in observed patterns and interactions within that data. Action research focuses on searching for an answer to resolve a particular issue, typically involving a team and collaborative approach to problem-solving (Denscombe, 2009; 2010; Pedlar, 2012). The inherent collaborative problem-solving framework is not congruent with my study aim or indeed with my participant group. The acknowledgements made here emphasise the importance in selecting a methodology that aligns with the individual characteristics and demands of the research inquiry and the participant group under consideration.

Ethnography stood out to me as the most appropriate approach for my study due to its capacity to facilitate an immersive exploration of the everyday worlds and practices of people who use heroin. Ethnography afforded me the opportunity to garner information and first-hand experience about their behaviours, activities, social relationships, and how they interacted socially within their rural environment. Ethnography enables the exploration of "*meaning"* embedded in the everyday lives of people or cultures (Lindesmith 1947; Finestone 1957; Becker, 1963; Sutter 1969; Agar, 1973; Biernacki, 1986; Waldorf, et al. 1991; Bourgois, 2003).

Ethnography has also been applied previously to people who use drugs to gain insight into their lives and recovery in rural (and urban) settings (see Adler, 1992; Moore, 1993; Briggs, 2012; Parkin, 2013; Smith, 2014). These studies highlight the benefit of employing ethnography when studying people who use drugs in diverse social and geographical contexts, simultaneously providing relevance and applicability to my own study. The exploration of participants' subjective experiences as they reflect and navigate their everyday lives provides a depth of knowledge, understanding and original information that other methodological approaches may not offer. To be present when social interactions take place and to be able to question, explore and investigate those interactions and find meaning to them is crucial to the aim of my study.

5.3 The ethnographic tradition.

Ethnography originates from seminal work conducted by German post-enlightenment historian Gerhard Müller, in the mid-18th century. Over 10 years Müller lived with and studied a community in Siberia, by immersing himself in their community and culture becoming naturalised to their way of life. Extended periods of study like this, Müller found, enabled access to everyday uninhibited behaviours, activities, communication, and interactions of a community but also affords the researcher time and opportunity to study, interpret and contextualise everyday behaviours, interactions, and activities. Bernard (2004), Brewer (2000) and Hamersley and Atkinson (2007) note Müller's initial work was reconsidered and developed by von Schlozer and Gatterer who introduced the "ethnographic concept" to academia (in the early-19th century), through their teachings at the University of Gottingen, Germany.

Later anthropologists such as Malinowski (1913) and Radcliffe-Brown (1926) (functionalists) developed and implemented ethnography as a paradigm as they followed British colonialists along trade routes studying people and cultures as they travelled "newly discovered" lands (Brewer, 2000). Levi-Strauss continued this trend into the mid-20th century developing and applying a structuralist framework. Their research gave rise to the traditional ethnographic construct, not only academically, but also in a tangible, physical sense. In this context the "physical sense" applies to ethnographers, characterised as white European males who travelled to distant lands, studying unknown people and cultures, before comparing them, often unfavourably, with their own. This Eurocentric perspective led to and perpetuated a distorted view of civilisations and their environments. It is important to acknowledge that many ethnographers were female (Alice Cunningham-Fletcher and Francis La Flesche 1911; Audrey

Richards, 1932), who were instrumental in developing sociology and anthropology as disciplines. Sociologists from the Chicago School of Sociology furthered the ethnographic tradition by developing and pioneering the "Chicagoan Tradition" and by doing so promoted the study of nearby "urban ethnography", which I discuss later in this chapter.

Ethnography spans multiple disciplines but is rooted in the social sciences of anthropology and sociology. It is historically and traditionally situated with qualitative research and an interpretative paradigm; it is a well-tested philosophy which stands in stark contrast to positivism. Interpretivism is defined by Lincoln and Guba (1985) as an acceptance that actors have multiple realities where both knowledge and truth are individually subjective despite having a shared reality with others. Interpretivists within sociology do not believe that culture can be quantified, controlled or manipulated to produce quantifiable data. Instead, they expound culture is dynamic, variable and susceptible to social and behavioural influences. Within the interpretive paradigm emphasis is placed on understanding the complex nature of human experience, how meaning is constructed and the cultures contextual nature. In contrast, scholars within a positivist tradition advocate for validity, reliability and generalisability and a fundamental conclusion to questions with the emphasis on the ability for a method to be replicated.

Ethnography, under examination, does not stand up to such scrutiny as the data collected are integral to the research practice. Instead, scholars such as Van Maanen (2011), Atkinson (2014) and Fetterman (2020) argue, it is valuable and important to gain the perspectives that the methods of the positivist tradition would simply miss, neglect, or even reject. Positivism, as Blumer (1969) of the Chicago School wrote, does not fit well when studying human behaviour. He argued that a true understanding of reality and meaning are acquired through direct interactions with people. This perspective challenges any conventional association of ethnography with positivism locating it firmly within the naturalistic interpretive realm. In this context, ethnography aligns with symbolic interactionism (analysis of interactions that focuses on the meanings people assign to things in their everyday worlds, i.e., objects or words) as its theoretical foundation.

The ethnographic tradition then is firmly situated within naturalistic interpretive paradigms (Hamersley and Atkinson, 2007), through which social processes are studied within their natural settings and are dependent upon natural constraints and social constructs. As a

qualitative research design, it is used to explore cultural phenomena and provides a rich in-depth vein of knowledge by allowing researchers to immerse themselves with and within cultures. This approach facilitates an intricate investigation of the nuances of social phenomena, rooted in an authentic context of participants natural environments. Ontologically (the nature of "being"), naturalism as with interpretivism relates to critical relativism, where reality is known through "socially constructed meaning" leading to many realities of the same experience (Annells, 1996; Hall, 1997) from different actors. Epistemologically (the nature of knowledge and its formation) they relate to subjectivity, self-monitoring of the "emotive and affective responses to participant" (LeCompte and Goetz, 1982, p.43), which is a numerous and diverse perspective of reality achieved through immersion within a culture. These methodological approaches allow in-depth explorations of peoples' worlds and realities, affording unique opportunities for researchers to integrate and participate in communities and interact with and record participants' activities, behaviours, and realities.

Ethnography is characterised by its inductive nature, no theories are evaluated, and the researcher can arguably start with a "blank sheet" (O'Reilly, 2009). Goulding (2002) argues that researchers cannot start with a "totally blank sheet" (p55) and cannot be totally void of influence. Social scientists, for instance, are inevitably influenced and shaped by the corpus of sociological thought and literature. Differing perspectives, prior reading and individual lived experience and inherent bias then, mould a researcher's approach, influence their interpretation of data and inform their construction of their research. How this can be mitigated by reflexivity is discussed later within this chapter.

Ethnography is fundamentally concerned with acquiring knowledge about people rather than studying them per se (Fereday and Muir-Cochrane, 2006). Ethnography is about discovery, rather than examination (O'Reilly, 2012) and usually, but by no means always, covers extended periods in the field. This allows researchers the opportunity to gain a unique insight into a culture and those connected with it by exploring that culture and the perceptions of everyday lives and specific phenomena (Hamersley and Atkinson, 2007; Jones and Smith, 2017) over a prolonged period. This, the researcher hopes, leads to their acceptance by the community, reducing or even removing barriers and obstacles that place and maintain researchers on the peripheries of the community as "outsiders".

Ethnography can be a useful methodological approach in situations where participants are hard to access and are marginalised, such as people who use drugs, particularly in rural settings. The ethnographic process allows a researcher to develop and gain the trust of potential participants, and in turn provide a gateway to and from their worlds (Meloni, 2020; Chamberlain and Hodgetts, 2018). It does not, of course, guarantee initial or continued access; reaching marginalised participants can result in innumerable dead ends and other frustrations when recruiting and engaging them. Because the researcher becomes known and accepted, ethnography can reduce any pretence participants may display because of being observed, thereby minimising any potential "Hawthorne effect" (conscious behavioural change by participants due to the influence of a researcher) (McCambridge, et al. 2014). In essence, the researcher becomes naturalised to a culture and community by living the life of their study subjects through immersion, written documents, discourse, nonparticipant observation and participant-observation which naturally invites triangulation, developing a nuanced understanding of those under study.

When employing ethnography in the field it often requires just one researcher thus enhancing ethical rigour where confidentiality is required. This is relevant when studying individuals engaged in socially unacceptable and illegal activities, such as heroin use. Moore (1993) and Brewer (2000) contend that retaining autonomy when collecting information also has the advantage of providing certain anonymity for the researcher, easing their participation in cultures, and promoting trust with participants which they cite as essential in data collection. Multiple researchers, however, can be involved in ethnographic studies; some researchers even include their families in their study process (Geertz, 1972; Bourgois, 2003), due to the length of time spent in the field and to assimilate within the culture under study.

Ethnography aims to explore and draw out any "tacit knowledge" - information about the culture so embedded that the community members may not even discuss or be aware of it (Hamersley and Atkinson, 2007). To achieve this, I independently entered the field to attain, as Bowers (1992) writes, insight into perspectives and realities from participants by learning *from* participants rather than objectively *studying* them. This required me to attain "insider" status, by gaining acceptance into their community to understand their culture from within. Doing so provided me with an "emic" perspective (Harper, 2008) as I lived their everyday lives and experienced their realities as much as I could without participating in potentially harmful behaviours. Ethical considerations prevented me from participating in potentially harmful

pursuits such as intravenous heroin use, although I was present when heroin and other drugs were purchased, prepared and used.

Webb, et al. (2002) suggest that Bourdieu relates an emic perspective to “habitus”, denoting the unseen and mundane actions of society that go unnoticed yet communicate important and intricate patterns of behaviour and information and which belies unknown knowledge about them. Hurley, et al. (2011) posits that ethnography allows identification between people and inanimate “things” and the meaning they hold for individual actors and communities. Crucially, ethnography has the capacity to reveal information from participants who may believe they have nothing of worth to say on a particular topic, but who are subconsciously influenced by or influence a particular topic, providing the researcher with an insight to this. Observations allow patterns of behaviour to be discovered, not dissimilar to Berger and Luckman’s (1966) “habitualization theory”. In this context repeated actions become a pattern of continuance and ingrained leading to other actors accepting them, acquiring them, and modifying their response and actions to them. Actors, due to their subjectivity, may not acknowledge these patterns but they may be identifiable to objective observation by an ethnographic researcher, thus what is not said or done is as important as what is.

Webb, et al. (2002) also cite observing what is not said or done as vital, for instance where communities and individuals are unaware of outside influences such as policies, laws, advancing technologies and global social changes. Influences such as these may happen outside an immediate community, geographic locale, or knowledge and understanding of an individual or group, but may still have an impact or bearing upon them, i.e., people who use heroin being affected by unseen or unknown drug-related policies, practices and influences. In contrast, unknown and unseen influences may also be created by an individual or community on wider society, giving rise to social change or challenging societal beliefs outside their immediate environment i.e., AIDS or HIV infection and transmission amongst people who use drugs (Giddens and Sutton, 2017; Neale, 2001).

In contrast to the “emic” perspective in ethnography is the “etic” perspective, which allows researchers to observe and describe communities and cultures and acts as a mechanism for analysis of people who influence “cultural phenomena” and communities under investigation (Madden, 2010) as outsiders. “Outsiders” are actors outside a community who engage, impact and influence it (positively or negatively), for instance, service providers and recovery

professionals who work with people who use heroin. Outsiders may trade with, aid or implement policies, protocols, laws and procedures, which may in themselves, have an intended or unintended positive or negative impact and influence. They can also influence societal perceptions of communities through their portrayal of them. The etic perspective is important to my study to provide insight into the interactions between people who use heroin and SDAS staff.

There have been several noteworthy ethnographies (see for instance Briggs, 2012; Parkin, 2013; Smith, 2014) within the U.K. that have concentrated on people who use drugs. The sociological literature continues to expand highlighting distinct perspectives regarding people who use drugs, drug use, associated behaviours and activities, recovery pathways, environments and treatment regimes. It is necessary to identify the diversity amongst people who use drugs and the various environments they inhabit as each offers a unique perspective and experience. In this context, my study contributes a unique and distinctive account of my participant's lives by exploring and presenting their everyday practices with heroin within a rural setting in Scotland and providing them with a voice. This then adds a unique dimension to the existing body of literature and offers an insight into the intricate and nuanced realities of individuals in this specific context.

In summary, ethnography has a long and rich tradition within social science as a qualitative methodology grounded in an interpretive paradigm. Its utility can be applied to study areas where an in-depth investigation is required to explore nuanced lived realities of individuals, cultures, communities, and interrelationships in detail. As a methodological approach deeply ingrained in qualitative inquiry it provides a conduit for researchers to explore the multifaceted dimensions of social phenomena using different interpretative methods to investigate the area of study. It also affords a means to identify "outsider" influence, whilst providing the time and opportunity for researchers to integrate and immerse themselves into the community to identify potentially unconscious knowledge, realities, activities and behaviours and any meaning they hold. Ethnography can facilitate access to marginalised groups involved in practices usually not socially acceptable, as in my case with people who use heroin. Such groups usually mistrust outsiders, due to fear of societal recrimination or legal prosecution by the criminal justice system. Ethnography's strength lies in its ability to promote relationships, allowing the development of trust and integration of the researcher into the everyday life of those under study. I consider how to apply ethnography in a study "on one's doorstep" using the Chicagoan

tradition as a framework for its guidance and implementation. which will be explored in this next section.

5.4 The Chicagoan Tradition- A framework for doorstep ethnography.

Building on the work of earlier ethnographers, the Chicago School of Sociology was instrumental in helping to develop this field from the 1930s onwards. This cohort of scholars had the insight to realise that ethnographic methods could be applied not only to cultures and people in of far-off lands but also to study cultures and people on one's doorstep (Fisher and Straus, 1978). The Chicagoan tradition, Harvey (1987) wrote, centred on analysing the influence of social structures, functions and the various physical factors within a social environment have on human behaviour and interactions. The Chicago school of sociology specialised in conducting "urban ethnographic studies", and explored the intricate dynamics of behaviour patterns, cultures, and communities within urban areas, such as drug use, homelessness, and gang culture. In essence, the city of Chicago served as a metaphorical "laboratory" for their research endeavours. Employing the Chicago tradition, I aim to enhance my thesis, using its robust framework and extensive literature to enrich my analysis and understanding albeit to a rural setting.

Smith (1988, p.6) wrote that the Chicagoan tradition can be used as a framework to "explore and examine misery, oppression and frustration imposed (on society) by modern America" which Tomasi (1998) and Short (2002) recognise are facets in urban and inner-city life and where, for instance, illicit drug use is commonplace. Tomasi also noted that the Chicagoan tradition has been applied to a diverse portfolio of topics focussing on groups (i.e., gangs), cultures (i.e., Afro-Caribbean), and deviance and marginality, (i.e., vice and criminals). Clinard and Meier, (2011) specifically site people who use drugs as a category of "deviants" in this framework. The Chicagoan tradition is therefore constructed by studying urban deviancy and the social actors involved, who are often found on the margins and peripheries of society (Short, 2002; Zorbaugh, 1929). These points resonate with my study group, and I can draw inspiration and guidance from the associated literature. My "laboratory", albeit rural, is metaphorically on my doorstep allowing me the opportunity to apply the Chicagoan framework to scrutinise the dynamics of the lived reality of people who use heroin and any related social phenomena.

The Chicagoan tradition is not just about urbanisation, rather, its focus is on "human nature and social order" (Smith, 1988, p.11) wherever these phenomena are to be found. This, Smith

(1988) argues, means that it can be applied to diverse contexts, such as a rural setting. The Chicagoan tradition searches out social order or disorder through open communication and rational discussion and is steeped in ethnographic traditions (Becker, 1999). It identifies data through the identification of phenomena developing a rich vein of knowledge from the lived experience of participants through discourse, pictures, narratives, participant-observation and nonparticipant observation. It has proven influential in studies encompassing people who use drugs and has been implemented by eminent scholars within the sociological field such as Bourgois (1995; 2003), and Taylor (1994) who themselves studied people who use drugs in urban settings.

Bulmer (1984), comments that every person, regardless of who or where they are, has a story to tell. It is down to the researcher to investigate and question their lives, exploring the "what's and whys" to gain insight in specific areas, but importantly, to provide more information than just a "mountain of statistics." Bulmer (1984, p.97) acknowledges that the principles of ethnography underpin the Chicagoan tradition in contextualising the "everyday" of study participants through interviews, nonparticipant observation and participant-observation, ending in "first-hand observation that provides *real* research." The Chicagoan tradition is best applied to the "weakest" in society (see for instance Thomas and Znaniecki, 1918; Zorbaugh, 1929), because those on the peripheries of society are more likely to engage with the Chicagoan tradition as it gives them a "voice" to express themselves, whereas the more powerful in a society are likely to be "guarded" to maintain their social status and ward off potential unsympathetic research or criticism (Abbot, 1997; Lutters and Ackerman, 1996; Smith, 1988). The Chicago tradition also gives the researcher "privileged access to meaning" (Tomasi, 1998, p.99) to understand the realities of participants and to access their worlds, reality, and their agency within them, wherever they are.

Tomasi (1998, p.43) goes on to explain that areas such as neighbourhoods can be studied, not only geographically, but also for what they reveal about human nature and everyday life. Crucially then, the Chicagoan tradition goes beyond geographic boundaries, such as urban or inner-city and can be applied to rural populations, such as small towns, villages, and hamlets. He suggests three steps to achieve a "thorough relational and interactive understanding of the reality of the neighbourhood", namely contact with concrete facts, the discovery of factors that are present in the situation, and the identification of forces operating within typical situations. All three steps can be applied to communities within rural settings because whatever or

wherever the community is, it designates individuals, families, groups, and institutions (Tomasi, 1998). Urban neighbourhoods are subject to segregation, demarcation and boundary lines that lead to geographic identification and isolation, similar to rural settings; cities for example are not just one sprawling homogenous arena (Santos, et al. 2010; Solecki and Welch, 1995) and conversely, rurality does not consist of independent pockets of society despite geographical distance. The application of ethnography using the Chicagoan tradition as a framework in a traditional rural setting allows me to target specific communities, from very rural areas to large rural towns and consequently, people who use heroin within rural communities and environments.

In summary then, drawing upon ethnographic traditions of data collection, the application of the Chicagoan tradition as a framework for collecting data and Braun and Clarke's (2006) thematic analysis (discussed later in this chapter) for analysing it provides a robust, powerful and tested framework within which I can implement my study. As a framework, it has a rich tradition within the landscape of sociology, and it acts as a powerful tool to assist in exploring the intricate and nuanced complexities associated with studies such as mine, whilst aligning with those principles embedded within ethnographic inquiry. Its application has proven effective when used to study human nature and social order, thus it will enhance the depth of my research. In this next section I will explore the challenges of implementing ethnography.

5.5 Challenges of using ethnography.

Brewer (1994) and Denzin and Lincoln (2008) assert that the major criticism of ethnography, mainly from those aligned with the positivist tradition who seek generalisable data that is both valid and reliable, is that it cannot lead to a conclusive argument to prove or disprove a theory or hypothesis. Hamersley and Atkinson (2007, p.17) posit that findings derived from ethnographies are often "shelved", the insight they offer lost, ultimately having a "lack of impact on policy-making practice". There is an enduring debate amongst social scientists (Ercikan and Roth, 2009; Larsson, 2009; Nurani, 2008; Verd, et al. 2020) questioning the extent to which ethnographic data can be generalised, if at all. The contention is due to often small study samples and fluid information garnered from participants with the researcher pivotal as both recorder and interpreter meaning they cannot be replicated. Accessing as many participants as possible to achieve data saturation, the point in the research process when there is no new information to be discovered presents researchers with a tool to defend their findings. However, Jones and Smith (2017) caution, that a shortage of time and resources can mean that

data collection ends abruptly so that data saturation is not achieved, and so potential generalisability of the data are uncertain. These factors highlight the inherent methodological challenges and epistemological consideration inherent when applying ethnography.

The evaluative criteria for qualitative research Pope and May (1995) argue, challenge the positivists traditions of reliability and validity suited as they are quantitative data. Trustworthiness and credibility are more apt terms interpretivist paradigms in qualitative research. Trustworthiness is founded by the researcher's trust in what the participants say and what is observed, interpreting and reporting this to "effectively represent empirical reality." Credibility involves the researcher making a credible account "assessing whether constructs devised by the researchers represent or measure the categories of the human experience that occur" (LeCompte and Goetz, 1982, p.32) highlighting the researcher's subjective involvement and consequently their potential influence on the research process.

Wright-Mills (1959) and Bryman (2001) warn that in applying an ethnographic approach the researcher's perspective and political leanings cannot be filtered out of data collection and analysis. This recognition leads Newton (2009) to question if the researcher can remain separate and neutral from the meanings that are constructed through their research process. Ethnography also introduces the very real possibility of the researcher experiencing a phenomenon known as "going native," the potential for some ethnographers, through their immersion in their study, to inadvertently become fully fledged members of the community under study (Harvey, 2012; Reilly, 2009). Conducting ethnography is challenging because of the need to encompass detailed ethical consideration, its inherent methodological complexities and the requirement for reflexivity to reflect dynamic interactions of the community under study, factors that I will explore in the next section beginning with reflexivity.

5.6 Reflexivity.

Hamersley and Atkinson (2007), although accepting of the challenges levelled at ethnography, advocate reflexivity as a means to explore differing ways in which the researcher's involvement potentially influences, informs, or affects the research and resulting findings. As a tool, reflexivity serves as a valuable mechanism for researchers to examine and scrutinise their subjectivity, particularly when it comes to the analysis and interpretation of data (Newton, 2009). It operates by providing transparency in tandem with the chosen research method thereby upholding the inherent beliefs and values that the researcher holds such as

political leanings (and the politics of any gatekeeper), that must be acknowledged and then set aside. Foley (2002) explains that researchers within the naturistic field must be aware of the potential for being influenced by those they are studying emphasising the necessity to maintain a neutral perspective. Reflexivity, as a result, is of particular importance to ethnographers (Carbo, 2008; Clark and Sharf, 2007; Dougherty and Atkinson, 2006; and Pfau, 2007) where the researcher may inadvertently become so immersed within their study group as to experience the phenomenon known as "going native." This would challenge their ability to sustain a neutral view through the unwitting absorption of their participant's beliefs and values. This may then influence and shape their perspective as a researcher, which would be reflected in their data collection and analysis. Employing and applying reflexivity through critical reflection or from support from supervisors for example, can eradicate, minimise or make known biases, whilst ensuring the method employed remains transparent and true to its values, and that data remains credible and trustworthy (Foley, 2002; Salzman, 2002; Braun and Clarke, 2006).

Assignation of moral values to social phenomena is commonplace including amongst researchers meaning pure value-free research is inconceivable. Weber (1904) stated in "*The Protestant Ethic and the Spirit of Capitalism",* that researchers should strive for "value-neutrality" impartiality and try to minimise applying moralistic interpretation throughout their data collection and analysis. Considering the need for reflexivity leads me to explain that I am a 55-year-old registered nurse with over 34 years' experience working within the NHS in Scotland and England. I have nursed and supported people who have used heroin at various times in my career and hold people who use drugs in deep regard. Although I am very keen not to personalise my study, my motivation is and always was to provide a voice for my participants. I also feel that my childhood on an impoverished Scottish east coast housing scheme in the 1970s in a community mired in drugs and drug use means that I can empathise with people who use heroin. It should be stated though that as part of registrant requirements to the Nursing and Midwifery Council (NMC), which regulates, develops and monitors the practice of nurses within the U.K., I am duty-bound to extend unconditional positive regard, informed consent, non-judgemental principles, equality, and confidentiality to all people, always. I carry these principles sincerely. The NMC also makes clear a duty to provide care. It states, "In or outside the work setting, you have a professional **duty** to provide care" (NMC, 2018, p.14). Failure to provide care or where there has been deemed a failure of "good character" (dishonesty, prejudice, violence, criminality), can mean removal from the register

and with it the right to practice as a nurse. Thus, even when conducting research, I am duty bound to protect children and adults at risk, by stepping in to assist and without exception report potential abuse, harm or risk to the appropriate authorities.

Of note is my professional and academic journey of being historically ensconced within the paradigm of the medical model of addiction, grounded as it is in my nurse training and professional background, to the adoption and application of a social perspective of addiction within my thesis. This transformation primarily occurred by an extensive exploration of literature pertaining to social perspectives of addiction, active engagement in sociological coursework and robust discussion and guidance from my supervisors. My supervisors played a pivotal role by availing themselves to regular supervision meetings and ad hoc communications, providing invaluable guidance. My journey was further shaped by my participant's narratives and experiences. They embodied various aspects from differing addiction and recovery models in their everyday practices and gave me pause for thought on the ontological boundaries of drug use, addiction and recovery. My initial perspective and understanding of drug use, addiction and recovery (and their associated models) developed throughout my studentship, which are intricately reflected throughout my thesis.

In summary, a distinct feature of ethnography is the need for reflexivity, which I employed as a valuable tool to identify and to reduce potential research bias, contributing to the method's robustness. In the next section, I will explore the ethical consideration pertaining to my study.

5.7 Ethics in my study.

Adherence to ethical principles is paramount to studies and researchers must be aware of potential ethical issues and any impact these may have on vulnerable groups so that ethical strategies can be developed to meet any potential challenges before they occur. Most disciplines, including sociology, formalised ethical principles after the Second World War (Bessant and Watts, 2007). The Nuremberg Code set 10 ethical principles (Kodex) to ensure the safety and informed consent of research participants. Williams (2008) wrote that in 1964 the Declaration of Helsinki further developed and updated the Kodex to reflect research that involved human participants, a position it continues to review and fulfil to ensure research is and remains ethical. The Declaration's main points are that participants provide voluntary and informed consent, and they are afforded freedom of choice, knowledge and understanding of all research to be conducted.

Campbell (2010, p.1) cautions researchers that within social sciences "ambivalence towards ethics should not surprise us…" This admonition emphasises the need for ethical application to be adhered to, lest ambivalence creeps in. To this end I referred to and drew ethical guidance from the ethical guidelines for good research practice from the Association for Social Anthropologists (ASA) (United Kingdom) Code of Ethics (2017) throughout my study. In 2017 I began a particularly long and complex ethical pathway by gaining ethical approval from the University of Glasgow (Social Science) College Research Ethics Committee which included a risk assessment for lone working and Occupational Health and Disclosure Scotland screening. I then sought and gained written approval from Dumfries and Galloway National Health Service who provide and oversee the SDAS unit and whose jurisdiction the participants fall under (Dumfries and Galloway NHS Research Ethics Committee, 2017). I then submitted ethical approval via The Integrated Research Application System (IRAS -number 216146), (NHS Scotland, 2017) and attended the NHS Scotland ethics committee meeting in Glasgow addressing questions from the 25-person strong ethics panel for over 30 minutes. Following their approval, I met formally with the SDAS senior unit managers to fully explain the research and ethical parameters and then awaited their final approval. Confirmation, however, required a meeting with the NHS Mental Health General Manager who has overall jurisdiction over the SDAS. Following approval from her, I gave a presentation to the SDAS team about my study proposal, concluding with a question-and-answer session. I then awaited and received positive confirmation from the SDAS unit team. Finally, I notified my employer, the University of the West of Scotland (UWS), who referred me to their ethics committee (UWS Ethical Committee), to ensure there were no conflicts of interest. Their approval concluded my engagement with ethical committees although IRAS and NHS Dumfries and Galloway ethics committee continued contact with me throughout my data collection period as did my supervisors from the University of Glasgow. All data storage and use met with the 2017 Data Protection Regulation Act (DPA) and were detailed within my study application for the various ethics committees.

I drafted participants' information sheets (see appendix 5) and consent forms (see appendix 6) in line with the IRAS approval, detailing my study on flyers (see appendix 7), displaying them in the SDAS building and providing copies to SDAS reception staff and nurses. I also displayed them within pharmacies that offer substitute medication and needle exchange services throughout the region. Participants were asked to read and keep the participant sheet and

encouraged to ask questions before informed consent forms were presented to be signed. Anonymity was assured at every stage of engagement, with the proviso set by the NMC Code (2015) for the continuance of my nursing registration where there was a concern for children or young people (under the age of 18 years) the appropriate authorities would be informed. This issue never occurred. Participation was voluntary, with participants free to leave at any point, their names and details have been replaced with pseudonyms to protect their identity and places of residence. In practice, my foremost ethical dilemma came down to the ability of vulnerable people and groups to make autonomous decisions regarding informed consent before participating in a research study.

My participants were people who used heroin, who are considered a "vulnerable group" by the European Centre for Drugs and Drug Addiction (2008). They can be designated vulnerable before using heroin, their vulnerabilities leading them to initially use heroin and then become dependent but also when under the influence of heroin, as its effect may lead to impaired decision-making capacity and judgement. This should not automatically prevent their inclusion in research. There is an expansive corpus extending over the past century devoted to research on people who use heroin (and other drugs), indicating an ability and acceptance that people who use drugs can engage with research. However, Anderson and McNair (2018, p.280) advise "there are no specific ethical guidelines for conducting research with people who abuse opioids, beyond those regulations, guidelines, and standards that apply broadly to human research. There is, however, a body of robust literature addressing ethical issues relevant to conducting substance abuse research." The evidence, Anderson and McNair (2018, p.282) suggest is "that to assume that all opioid addicts lack DMC (decision-making capacity) or are even similarly vulnerable is to ignore the diversity of this population." Sana-Loue and Ioan, (2007, p.214) argue, heroin "addicts are cognizant of the choices available to them" therefore are considered capable of informed decision making unless they are very intoxicated or in severe withdrawals and deemed incapable by the researcher of giving informed consent."

The capacity for informed consent then is no different for people who use drugs than for those who do not (Harrison, et al. 1995; Bell and Salmon, 2011; Bell and Salmon, 2012). Indeed, McCrady and Bux (1999) found that the capacity to retain information regarding consent given for individual who use drugs was "typically similar" to those people who do not use drugs. I carefully considered the type of questions I was going to ask and how these could and would be asked to minimise any emotional impact upon the participants, to prevent potentially "re-

traumatizing users and re-victimizing them" (Bell and Salmon, 2012, p.191). As a trained and experienced counsellor, I felt I could initially resolve issues or change an emotionally challenging topic in response to a person's reactions, but I also knew when to signpost participants to services, such as their SDAS keyworker or General Practitioner where and when appropriate.

Ethical consideration also extended to being near illicit drugs, their use and associated criminality, some of which I resolved not to engage in. I was also aware that conducting my research where I live may inadvertently bring me into contact with participants when I was not "researching." This proved to be a very regular occurrence. On the occasions when unplanned interactions occurred, I exercised discretion by awaiting acknowledgement from the person before responding. My approach reduced placing undue pressure on them to engage with me and mitigated potential awkwardness. Such meetings provided several unscheduled and spontaneous discussions, adding an unexpected yet invaluable dimension to my study.

Incentives were not used to engage participants; it was important for my study to ensure all involvement was down to free will and participants were free to leave at any point without reason. Publication of data via this thesis will remain locked for 5 years following its submission, due to potential sensitivities recorded by SDAS clients about SDAS staff and to protect SDAS regarding opinions they asserted about clients, other staff members or their employer.

An additional ethical consideration was the formulation of an exit strategy. Within ethnographic research, relationships evolve and develop within the field, leading to friendships between the ethnographer and participants. Suitable exit plans, therefore, need to be considered lest the participant feels "used" (Morrison, et al. 2004). Where and when relationships were casual, I employed social etiquette as an exit strategy. For more meaningful relationships, Morrison et al. (2004, p.424) found in their study of overweight adolescent boys in Canada, that "defined relationships can continue between the participant and the researcher post-research." This aspect was of relevance as I live close to some participants. As it transpired, of the five people I developed meaningful friendships with, two sadly passed away (one with acute physical illness, one due to heroin overdose), two were incarcerated in prison in England (for drugs trafficking) and one unexpectedly left the region within 5 months of the fieldwork ending.

I also faced the constant temptation to dissuade individuals from injecting heroin, to preach about the associated dangers and risks, to provide medical assistance by dressing wounds, and to inform the SDAS about the realities of their clients' lives. However, I realised that taking such actions would blur the lines between my roles as a researcher and a nurse, potentially influencing participants' behaviours and, consequently, the data collected. I toyed with engaging with heroin-related behaviour such as being present when participants were trafficking out of region and going shoplifting in Manchester to enhance my "lived experience", all of which I refrained from for fear of prosecution, which on reflection I now regret because it limited my overall experience. My main ethical issue, the one that kept me awake at night, was whether to administer the opioid antagonist *naloxone* or not when I was unsure if participants were overdosing. On the few occasions I did consider administering naloxone I refrained, spending several anxiety-ridden hours nearby as I employed my medical training to monitor their well-being, leaving only when assured of their safety.

In summary, prioritising and upholding ethical values and ensuring beneficence is paramount to the safety and wellbeing of participants, regardless of their purpose, the study parameters or the environment in which they are engaged. Safeguarding these principles is to ensure grounds for epistemological rigour and adherence to ethical principles is a central tenet of all research (Iphofen, 2011) including my own. I now move to consider the intricate process of fieldwork, detailing how I identified and recruited participants, and my data collection and analysis.

5.8 Fieldwork.

Within the following section, I explain who my participants are and how they were selected, and at the same time consider the challenges I met during selection. I then describe my data collection and reflect on the process before detailing my data analysis.

5.8.1 Accessing participants.

Ethnographic access to participants is sought following ethical approval and extends to individual and group invitations or using third parties for introductions (Duncombe and Jessop, 2002; Hamersley and Atkinson, 2007). Bengry-Howell and Griffin (2012, p.405) wrote that "field relations are mostly established through a discursive process which involves differing degrees of rapport management," a skill I have developed as a mental health nurse. I was seeking to include participants who had used heroin within the previous 3 weeks and self-

reported as “heroin addicts.” The very illegality of heroin, however, and its use had a bearing on my ability to find, meet or make initial contact with potential participants. Theirs, as found in other studies such as Biernacki (1986), Hser, et al. (2007) and Best, et al. (2011), were not behaviours or activities that were overt. They were secretive, a hidden population, mistrusting for fear of being caught by the police and processed through the criminal justice system. Recruiting informally then did not work. In the end, an NHS SDAS based in Dumfries which covers the region of Dumfries and Galloway was used as my point of entry to the field. The team of specialist drug and alcohol nurses functioned as gatekeepers, from where I expected, but ultimately failed, to use snowball sampling whilst in the field to access other potential participants.

The SDAS has facilities throughout the region and provides addiction and treatment services including social, and mental health support and substitute prescribing, such as methadone or buprenorphine used to engage people who use heroin. Other potential points of contact within the region were Add-Action, a charitable organisation that tenders for funds from the local authority in Dumfries. They employ outreach workers throughout the region, offering support to recovering and recovered people who have alcohol and substance use disorders. People who used heroin did not attend Add-Action, as they did not offer anything more than SDAS in relation to benefits or support and crucially, did not provide substitute prescribing at all, thus I did not recruit participants through this organisation. Another potential source I investigated was the local prison (which houses sex offenders) and although it did have some “general population prisoners” (non-sex offenders), few were from Dumfries and Galloway and prison authorities reported prisoners did not have access to drugs. Thus, they did not meet my participant criteria.

The SDAS provided me with an initial introduction to potential participants. I then had to develop their trust and explain that I was independent of the SDAS. I had to reassure participants, often on several occasions, that all information I gathered was confidential and would not be discussed or shared with members of the SDAS team or criminal justice service. I also had to explain to SDAS team members I would not share any information about participants with them, nor was I to be considered a conduit for communication or vicarious assessment of their clients’ well-being, given that my views as an experienced nurse were sought by nursing staff. I originally intended to use snowball sampling, progressing from participant to participant. However, this approach was thwarted as people who used heroin

would not introduce me to others involved in drug use. This reticence was stemmed from adherence to the social etiquette of "not grassing", in other words, not providing personal details of friends or colleagues; it was also underpinned by the lack of shared venues for using heroin and geography. Thus, it was only by chance I met one participant through snowball sampling, who was briefly "couch surfing" when I met them in a key informant's house.

On reflection, without the SDAS I would not have been able to meet people who used heroin. All my participants were registered with and attended the SDAS. However, this only represents approximately half of the people who use heroin within the region; meaning and estimated 750 people who used heroin are not represented in my study. My inability to initially engage people who used heroin through more informal routes was principally due to my "outsider status." I do not use heroin and have no direct access to those who do and originally hailing from Edinburgh, my accent stands out starkly compared with the local dialects especially those of Stranraer. However, over 25 years of living and working within the region meant I have achieved "geographic identity" and can decipher and interpret the colloquialisms and dialects of the region and I am accustomed to its geography and culture. I am also an experienced mental health practitioner and accustomed to engaging and maintaining relations with marginalised individuals.

5.8.2 Participants.

Participants were identified and invited to participate according, in part, to theoretical relevance and my study parameters for inclusion (see next section). To maintain confidentiality, names were anonymised, and participants were allocated pseudonyms along with associated places or characteristics that may identify them (in line with ethical approval). Ages and genders are correct as is the identification of Dumfries and Galloway, central to the study because it underpins and emphasises the rurality of the geographic area studied. Participants' residencies spanned from a few hundred metres from my own residence to 78 miles at the furthest point of the region. I recognised several faces of people who lived close to my home address, although I was unaware of them until my study commenced, a factor identified in the Chicagoan tradition. To reiterate, participants were free to leave the study at any point without reason or bias. The potential participant pool comprised of a cohort of 750 people who actively used heroin, all registered with and attending the SDAS. I hoped to meet about 10-20 over a 12-month period, from January 2018 to January 2019, allowing me a minimum of two to three days per week immersed in the field.

All participants (N-51) reported active heroin use (intravenous and inhaled; all used other drugs). All identified heroin use for at least 3 years, many for decades before our meeting. Only one participant self-identified as a "heroin addict". The remaining participants preferred the term "drug users", thus my participant selection criteria evolved to include people who use heroin who identify as "drug users." From the 51 participants I engaged with, I developed 5 key participants, with whom I established sustained engagement, meeting them on numerous occasions throughout my time in the field.

Spatiality and geography were instrumental to my study aims, and participants were required to have been resident and living within rural Dumfries and Galloway for a minimum of six months to be eligible for inclusion. It was important for my study that participants were immersed in rural living and life and had experienced heroin use whilst resident there so they could give a representation of their everyday rural lives and practices. The shortest period a participant had lived within the area was approximately 3 years and to achieve maximum participant variance I travelled throughout the region at dates and times that suited participants, ensuring third parties were welcome if they so wished. All spoke and could read English, to a comprehensible level, including one Polish participant. The purposive (selective) sampling approach led to the inclusion of mixed-gender adults using heroin, aged eighteen years or older (18 is the youngest SDAS accepted for referral purposes). There was no upper age limit set, allowing for the inclusion of participants covering a wide age range, the oldest person "on the books" was 62 years old.

Strong local dialects, in particular participants from Stranraer (Galloway-Irish accent), proved the main obstacle to communication, however, words and phrases were clarified with participants where and when necessary. It was important to me to present my data collection in the vernacular to lessen any potential obfuscation and to build on the perspective from the cultural memory of interactions. I concur with Keightley and Pickering (2013) that the use of vernacular assists in embedding the reader into the everyday reality and experience that is being conveyed. The Scots language is an Indigenous language distinct from English although it shares commonality with many words but offers nuanced meanings in the context of my participant's lives. Where the vernacular proved too challenging to scribe, in the case of one participant from the far west of the region, I have had to translate directly to English.

One last point of note is that in addition to my participants, an unexpected element of my study was that I formed relationships with SDAS staff and found them to be a rich source of information offering a unique perspective on rural heroin use and those who use it. My interactions and discussions with them were neither planned nor indeed sought. They were spontaneous but valuable with regards to providing information, clarity and opinion about heroin use, those people who use heroin and the spatial setting. They also explored the application of treatment, recovery, and strategies amongst the region's drug using community. I asked for and was granted verbal consent when making notes of our conversation assuring anonymity and confidentiality to those who spoke with me (N20).

5.8.3 Data collection.

Ethnographic data are traditionally collected through observation, participant–observation, nonparticipant observation, interactions, written word, or interviews (semi-structured and unstructured), with data being recorded through field notes, audio-visual recording, verbatim transcription, or by taking or making pictures (Denzin and Lincoln, 2017; Gans, 1999). The main problem with ethnographic data collection, Herman and Bentley (1992) posit, is the vast amounts of data generated. Data in the form of written notes on behaviours, discussion, and actions require analysis and the more data that is generated, the more analysis is needed, increasing the time that is needed. More data, however, LeCompte and Goetz (1982) argue, invariably leads to a greater quality of codes, themes, theories, categories, and insight during the analytic process. Deciding when, where, and what data to collect can also prove challenging. Too long spent collecting at one juncture risks missing data elsewhere, whereas not enough time spent collecting data, conversely, leads to vital information being missed. Data collection is also subject to the study's time constraints and available resources, placing the researcher under pressure to decide what to collect, when to collect it and identify what constitutes "enough" data, which is an ongoing debate amongst qualitative research scholars (Allan and Skinner, 1991; Angrosino, 2007; Fusch and Ness, 2015; Pool, 2017).

Within the sociological domain, ethnographic data collection is often cited as "fieldwork", defined by Coffey (2018) and The National Geographic Society (2018) as a process of observing people, their cultures, and their natural environments, to collect information about their everyday. Fieldwork, they argue, allows the researcher to examine and explore spaces and places and to discover the people and cultures within them, dovetailing as it does with ethnographic principles. Fieldwork is not to be conducted in controlled and sterile

environments such as classrooms or scientific laboratories, however, as these represent unnatural surroundings that inhibit natural behaviour (Brewer, 2000; Denzin and Lincoln, 2017). Consequently, fieldwork is suited to people's natural environments, their homes, and wider communities.

5.8.4 Data collection methods.

Participating in ethnographic research afforded an opportunity to immerse myself within the everyday lives and practices of my participants. There are subtle nuances in the application of data collection methods of ethnography pertaining to observation that researchers must be mindful of. I employed a combination of participant-observation (PO) and nonparticipant observation (NPO) as primary methods of data collection. These were complemented by both field notes and unstructured interviews, varying from minutes to hours in duration. The nature of some of my participants' behaviours, which involved illicit and criminal activities, sometimes restricted my direct participation. At these times, I applied a nonparticipant observation method, allowing me to observe their activities and behaviours without full participation in them.

Liukkonen and Astedt-Kurki (1994) comment that PO and interviews, rooted in symbolic interactionism, form a scientifically grounded approach providing general data, whilst allowing for targeted research inquiries. Hockey and Forsey (2012) emphasise that PO is conducive to producing ethnography, including interviews and nonparticipant observation. Gans (1999) wrote "PO could supply empirical findings about little known or stereotyped populations, particularly those outside the mainstream" yielding empirical findings from groups such as people who use heroin. Gans (1999) and Kawulich (2005) highlight the utility of PO in social sciences and its routine use in prolonged immersion in the cultural and social contexts. PO involves systematic participation and observation of a group's behaviours, interactions and rituals, and is often complemented by unstructured interviews, cultivating an "insider" perspective. Active participation builds rapport and trust, facilitating a nuanced understanding of the group's culture, perspectives, values and experiences. PO is valuable for extracting tacit knowledge from groups considered experts in their culture (Spradley, 2016). This develops a contextual understanding of the meaning that underpins the group's behaviours, social dynamics and rituals. It offers both "insider" and "outsider" perspectives, exploring interactions with external parties with whom the group interact (Iacono et al. 2009). PO's flexible approach to data collection, allows researchers to adapt methods and research questions

to diverse encounters and evolving insight, crucial when considering the dynamics of social interactions. Atkinson and Hammersley, (1994), Spradley (2016) and Reinharz (2017) identify common challenges with the application of PO as copious, difficult to generalise data, inherent subjectivity and bias, with a potential for "observer effect" altering natural behaviours, limited sampling size and, replication difficulties with the risk of researchers "going native".

Sitting juxtaposed to participant-observation but intricately linked to it, Morgan-Trimmer and Wood (2016) define nonparticipant observation, as a method involving observation without direct involvement. Roller and Lavrakas (2015) expand on NPO, highlighting onsite nonparticipant observation, which occurs at the usual location of the participant's behaviours, and offsite nonparticipant observation, referring to observation of online communities. NPO offers a level of detachment, especially where ethical concerns arise such as criminality or harmful behaviours, allowing the researcher to remain objective and reduce potential bias because it has less impact on natural behaviour in comparison with PO. However, the application of NPO carries the potential risk of researchers missing subtle nuances and insights that active participation may reveal or there may be misinterpretation of observed behaviours that PO could provide. Both PO and NPO encounter issues related to informed consent, confidentiality, and ongoing reflexivity. Data from PO and NPO are typically recorded as field notes, diary entries and audio-visual recordings, generating rich qualitative data that can surpass what is obtained though alternative methods such as interviews alone.

Reflecting on my own experience, I engaged in extensive periods of participant-observation and nonparticipant observation in the field, requiring consistent and immersive engagement with my participants. I accompanied participants in a variety of settings leading me to "hang out" with them in their homes and communities. Augmenting my understanding involved actively engaging in and observing everyday activities and routines of participants and interacting with individuals known to them. My participation and observation led to first-hand accounts involving the trafficking, sales, purchase and use of drugs. My roles often extended to monitoring for overdose, assuming a proxy security role, disseminating information on substances, being a "listener" and occasionally using my vehicle to transport participants. I abstained from any drug use, politely declining offers of substances such as heroin; however, I routinely observed participants prepare and use drugs, recording my findings in my field notes and mental memories, which I recalled later.

Time spent in the field included participation in routine, ostensibly mundane, everyday activities and practices, such as shopping, household chores, watching television and regional bus travel. Nevertheless, such engagement facilitated novel insight into the lived experiences and daily reality of rural people who use drugs. Participation routinely involved dialogue (often "banter") and listening to participant's narratives, observing and clarifying behaviours, interactions, discussions and meanings as they unfolded and documenting encounters through comprehensive notes and memos. I tried to capture the nuances and intricacies of my participant's daily lives and interactions. Time with participant's spanned different dates and times ranging from brief encounters to extended periods demonstrating my ability to remain flexible and adaptable to meet the needs of the group, whether departing upon request or responding at short notice.

Occasionally I was refused information or asked to leave a premise or area by people who did not know or trust me. Over time, I cultivated a rapport and trust with the group, and a reciprocal acceptance developed thus it became easier to access individuals, information and areas. My inclusion solidified my position as an "insider" and PO and NPO significantly honed my research skills and techniques as I became familiarised to nuanced language, behaviours, protocols and individuals within the community. This familiarity proffered a profound understanding of their customs, interactions, values, and group dynamics, many of which were concealed and went unnoticed by mainstream society. Subsequently, I endeavoured to present an authentic portrayal of my participants in my data in the following chapters, in a lucid and unbiased manner.

5.8.5 Data recording

At the outset of my study, I employed a digital "Dictaphone" to record interviews. However, from the beginning, participants consistently displayed unease when they saw it and refused to engage with me in its presence. This stands in contrast with Briggs' (2012) ethnographic study of "urban crack cocaine users" in London where participants were amenable to the use of recording devices. Whether this was to do with the main drug of choice or setting is unclear. Photographs were also unwelcome as participants expressed a lack of trust in these collection tools, fearing legal implications should the criminal justice service obtain and use any information to prosecute them. I respected and honoured their wishes and dispensed with both. Consequently, there is a notable absence of digital recorded transcripts and photographs resulting in a complete absence in my data of verbatim recorded

transcriptions. This presented a dilemma, as previously noted verbatim transcripts are commonly used by ethnographers to maintain the authenticity and richness of the participant's language, ensuring an accurate representation of the cultural context and nuances encountered in the field, thus underpinning data integrity. In lieu of verbatim transcripts I employed vernacular hand-written field notes and mental memories, complemented by follow-up interviews to gain clarity and ensure accuracy and visual descriptions and drawings of the people and their environments as recommended by Schatzman and Strauss (1973) and Kutsche, (1998).

I was keen to retain vernacular notes, even without verbatim recordings, principally because this was the route I had chosen when I initially thought I would use recordings and because they provide a true reflection of my participants and because this was what I had initially agreed to do with my supervisors. Developing the ability to document extensive vernacular notes swiftly and accurately was an essential skill I had honed during my tenure as a mental health nurse from the early 1990's onward. This skill proved essential for maintaining detailed case notes, capturing conversations and activities necessary to patient care and nursing management. These records played a pivotal role in situations such as the application of the Mental Health Act Scotland (1984). The vernacular notes served as detailed documentary evidence to support, rescind or challenge the application of the Mental Health Act and thus had to be accurate and extensive. Crucially, they provided records for patients, especially during periods where mental ill health led to a lack of insight and capacity. These notes provided patients with an accurate insight to the events leading to the necessity for the application of the Mental Health Act and fostered the nurse-patient therapeutic relationship through enhancing their general understanding of the need and rationale for potential treatment pathways, some of which were given against the patients expressed wishes.

Throughout my field work I diligently recorded field notes (appendix 8) to ensure accuracy as highlighted by Hamersley and Atkinson, (2007). My note taking extended to extensive commentaries written in the vernacular of the participant, "headnotes" (mental memories), and short points noted within my journals. Schatzman and Strauss (1973) stress headnotes and note-taking are suited to induce images and recall memories of a scene. I also wrote extensive memos and passages about complex conversations, settings, and non-verbal communication I observed or was involved in. I drew upon studies by Agar (1980), Best et al. (2011), Bourgois (1995; 2009) Larkin and Griffiths (2002), Mars, et al. (2013) McKeganey (2005) and Neale, et

al. (2010) for guidance on observed data collection values and application. I routinely asked participants to repeat what they had stated, or to clarify what they had said or meant at the time of the interaction and routinely revisited participants, when possible, to ensure what I was documenting was an accurate representation. To the best of my ability, I diligently documented direct quotes enriching them with details from non-verbal communication to emphasise congruence and associated behaviours, noteworthy interactions and visual depictions of the environment. My notes, detailed and meticulously handwritten, were recorded in numerous small note pads (see appendix 8) so as not to be intrusive, but with the participant's permission. I invested extensive hours not only capturing field notes but also using them as prompts to recall and stimulate memories. This iterative process allowed me to refine, enrich and expand my notes daily, mitigating the risk of data loss or its misrepresentation. This methodological approach afforded me the opportunity and flexibility to revise any data as necessary whilst underpinning data integrity.

To enhance data collection, I met and spent as much time as possible with participants in their chosen environment. Anyan (2013, p.2) identifies this immersive strategy helps to address and minimise potential power imbalance inherent in the researcher-participant dynamic promoting natural interaction to achieve "egalitarian status for both the interviewer and the interviewee." My data collection efforts were strategically concentrated on participants' "everyday lives and practices", which extended to and included heroin use and "dealing". It is noteworthy that ethical consideration continually guided my data collection which, as highlighted previously, excluded certain illegal scenarios such as "shoplifting" and "bringing gear down from Glasgow." These activities, although illegal, would have provided further insight into participants' realities.

Several texts, such as Denzin and Lincoln (2017), Flick (2014), and Hamersley and Atkinson (2007) emphasise that qualitative data is challenging to access, and consequently, determination by the researcher is crucial when collecting data. Determination though must be balanced with ethical parameters and participant confidentiality. In pursuit of a comprehensive understanding, I conducted data collection in various settings, including people's homes, local environments, pharmacies and private rooms at the SDAS. Cultivating a nuanced perspective led me to learn how to "hang out" with participants in restaurants, shops, cafes, bars and on public transport. In doing so I met their friends, acquaintances, family, and significant others and viewed how they interacted with people who did not use illicit drugs and vice-versa.

Together these enabled me to explore the wide range of social dynamics and interactions that shaped and constructed participants' lives.

Notably, people who used heroin were not found congregating on street corners, in squats, underpasses, or meeting in "shooting galleries", traditional areas associated with other studies (Biernacki, 1986; Bourgois, 1995; 2009; Andrade, et al. 1999) and portrayed in the media. In contrast, there was a distinct pattern that participants identified with, with one participant, who reported a long-term history of substance use, cogently explaining, "People prefer tae yase in thur ane hoose tae cook an' score….alweys huv" (Harold, 46 years old). The departure from traditional and expected settings for drug use underpins the necessity for context-specific data collection.

My data collection was comprehensively and meticulously conducted throughout Dumfries and Galloway's "five areas" (table 1) to provide a well-balanced representation of the region geography, people, and socio-cultural dynamics.

Area	Geographic relation to Dumfries	Main population centres
Wigtownshire	Far west	Stranraer and Newton Stewart
Stewartry	West	Dalbeattie and Castle Douglas
Dumfries	Main administration and population centre	Dumfries Town
Nithsdale	North	Sanquar, Kirkconnel/Kelloholm and Thornhill
Annandale	East, directly bordering England	Lockerbie and Annan

Table 1. Dumfries and Galloway's regional areas.

Data collection was made easier for me as I had previously worked with people who used drugs. I understood their parlance and to a point, required etiquette, when discussing drug use and associated paraphernalia. My pre-existing knowledge assisted me to assimilate with my participants within their environments. To "blend in" as Bourgois (1995; 2009) suggested, I consciously dressed in what *I* thought was "appropriate attire": jeans, polo shirt, hoodie, and

trainers, I was unshaven and allowed my hair (which is limited) to grow. Most of my participants, however, were well-dressed often in designer attire, were well-groomed and well-kempt. Several proffered fashion advice to bring me into the "21st century", and one proffered their barber's card. I used public transport whenever reasonable to do so to experience their routines and gain insight into their means of their travel but offered no incentive, financial or otherwise, to induce participant engagement- it had to be given freely and in no way be coerced.

In the process of data collection, I was led by participants when it came to spending time with them. Some participants were more open to spending extended periods with me, leading to a core of "key informants", some leading to friendship, others I met only briefly as they excused themselves to be "elsewhere." Data collection became notably easier the longer I spent in the field. The more time I spent immersed with participants the more familiar and relaxed we became in each other's company which, fostered trust, a positive factor identified by researchers such as Bourgois (1995; 2003) and Biernacki (1986). The study's time constraints brought my data collection to an end after 12 months. With reflection, I understood that by the end of my time in the field I had come to be accepted by my participants. Notably, it was in the latter stages of my time in the field that the most in-depth information was found. Conversations were easier, information was given freely without guard, I was invited to participate in activities without question and "banter" was notable. In line with data generation in ethnography, my study generated screeds of information, reflecting its depth and richness. I applied analysis from the study's initiation, the sheer volume, however, often left me feeling overwhelmed by the amount of data I produced. This sentiment was tempered by my wish to meticulously capture and record the information accrued as accurately as possible.

My data as noted was drawn from multifaceted approach, encompassing unstructured interviews and direct questions, nonparticipant observation, and participant-observation. These methodological approaches explored various aspects of participant's lives in the context of heroin use, elucidating details about relationships and their dynamics, lifestyles, what led to heroin use, addiction, why they kept using heroin and their relationship with SDAS and recovery. I spent time immersed in the company of my participants observing, interacting and being part of their everyday (lives, activities, practices). Participants, in turn, were often very keen to talk and include me in their lives, which surprised me. It became apparent that some were lonely and welcomed the interest I showed in them and their narratives. This was noted on several occasions when participants would openly engage with me but appeared very

reticent in engaging with SDAS staff or drug-using acquaintances. Sensitive and personal information was routinely disclosed within their narratives demonstrating the trust that was established between us. The immersive nature of my data collection often placed me in proximity with illicit transactions, activities and criminality, whilst these raised ethical considerations; they also enriched the data and authenticity of the research. It was from these immersive interactions that I gained insight, understanding and information about the lives of people who use drugs within a rural context. Their narratives and activities provided by the participants were their unique perspectives and roles, and the findings drawn from these represent their "voices" and consequently, the themes that were generated are inductive and representative of the participants lived realities. It is also important to acknowledge at this point, that all interactions were conducted with a judicious balance, taking into consideration my own personal safety, anxieties and potential risks.

Although my research objectives provided initial and essential guidance, upon reflection, they lead me to give prominence to aspects of behaviour and recovery associated with substance use that I had gleaned and expected from empirical sources. However, as my immersion in the field progressed, I quickly began to favour the authentic "real world identities and lives" of participants I met. My change in focus was further reinforced with time spent in the field, prompting me to engage with reflexivity and challenge and re-evaluate my own preconceived beliefs and perspectives also. As my data collection unfolded, I became more open and less fixed in the application of my research objectives and some conceptual perspectives I held. My shift although reflecting flexibility, led to substantial amounts of data, meaning I gave prominence to phenomena and data that I considered novel, and which sometimes challenged empirical discourse on people who use drugs and drug use itself. This methodological adaption resulted in the generation of findings that I did not expect and surprised me, allowing me to make unique assertions drawn from my data. This iterative process of refinement and adaptation, however, highlights the dynamic nature of qualitative research data collection.

In summary, the application of ethnographic data collection strategies affords comprehensive opportunities for gathering data through a triangulation of participant-observation, nonparticipant observation and interviews incorporating both emic and etic perspectives. Data generation can be (and was) substantial following extended periods immersed in the field, however, it facilitated unforeseen levels of openness, candour and warmth from the

participants. I was surprised at their levels of engagement which provided a unique and intricate insight into their worlds and realities.

Notably, there was division in the activity phases of qualitative research, which means data collection and analysis ran simultaneously, allowing me as a researcher to analyse as I collected data, reducing the amount of time needed to devote to analysis (Pascale, 2011). The substantial amounts of data I generated within my notebooks required meticulous analysis to prioritise and discern relevant information, and by doing so allowed me to distinguish essential and non-essential data. In the following section I will elaborate on my data analysis methodologies to clarify the analytic processes I chose to apply to my dataset.

5.9 Data analysis.

In this section, I will explain the process of data analysis characterised by a reflexive approach and based within qualitative research principles, and how it allowed me, as a researcher, to unlock and interpret my data. Brewer (2000, p.105) defines analysis as "the process of bringing order to the data, organizing what is there into patterns, categories and descriptive units, and looking for relationships between them." Hamersley and Atkinson, (2007, p.199) wrote that ethnographic analysis, in the main, provides "meaning and reason to reported events through contextual and processual presentations." Within the realm of qualitative research, data analysis is considered an iterative and dynamic process that involves continued refinement and interpretation. Its aim is to identify the complexities and depth of human perspectives, experiences and interpretations. The inherent nature of the data and its social construct relates to the co-construction of subjective knowledge and realities between researcher and participant. Notably, Hamersley and Atkinson (2007) emphasise that ethnographic data analysis is neither formulaic nor methodical as it is in quantitative research. It adheres to a systematic and interpretive framework to identify meaningful insights, discerning patterns and overarching themes. Data then are collated and explored to find similarities, categories and themes whilst also identifying potential abstract phenomena. Abstract phenomena may not be easily categorised, but they may underpin a new or unique phenomenon specific to the topic under enquiry and thereby present original and novel world views (Lofland and Lofland, 1984).

My analytical approach, having drawn on initial deductive analysis in the earlier stages of my thesis development, used inductive reasoning to develop principles from my copious field

notes. I employed an iterative process, routinely adhered to within ethnographies, simultaneously collecting and analysing data, allowing me to develop concepts and themes. I instituted thematic analysis to analyse my data, a well-known heuristic technique commonly implemented by social scientists using qualitative methodologies such as ethnography when researching drug-related behaviours and topics. Thematic analysis is known to be a straightforward yet robust method, with clear and easily interpreted steps on how to apply it to data, which is routinely used with ethnography. I used thematic analysis as a "tool" in line with Boyatzis (1998), although I recognise that there are scholars who argue that thematic analysis is considered a "method" in its own right (Harper and Thompson, 2011; Castleberry and Nolen, 2018).

In my application of thematic analysis, I drew upon Braun and Clarke's (2006) methodological framework for guidance. They have established well-defined guidelines on how to conduct thematic analysis of the data, however, I remained cognisant of their cautionary note that the plurality of thematic analysis due to its many iterations differs "paradigmatically, philosophically and procedurally" (Braun and Clarke 2019, p1), which is often overlooked by those employing it. Many of its associated problems are underpinned by the assumption of homogeneity in thematic analysis, and the resultant potential for bias or assumptions. Despite its inherent challenges, Braun and Clarke's thematic analysis is, however, praised for its flexibility, adaptability, and ability to generate meaningful insights from qualitative data, thus ensuring the qualitative data adheres to the standards of "correct Q."

It is also acknowledged by Braun and Clarke that it errs toward an overemphasis to an inductive approach and subjectivity. I balanced the potential for an overemphasis with an inductive approach by applying initial deductive reasoning at the start of the analytical process. Reflexivity, a fundamental sociological principle, was also a paramount consideration to counterbalance subjectivity and avoid bias. To ensure my thematic analysis was achieved in a reflexive manner, I was proactive in employing reflexivity throughout my study. I considered my personal and professional understanding of drug use and people who use drugs by reviewing why I had chosen to conduct my study. I also scrutinised my field notes that detailed my interactions and reflected on my own thoughts and feelings. These factors helped me to considerer and reconsider any preconceived notions that I held so I could comprehend any new phenomena identified within the context of my study.

To assist in the application of thematic analysis I adhered to Braun and Clarke's (2006) established 6-phase framework, which is known for its clarity of use on how to apply thematic analysis of the data and utilised Braun and Clarke's (2019) 20 question tool for guidance.

Step 1: Become familiar with the data. Research is read and re-read to comprehend its content, fostering context and highlighting notable patterns or interesting features.	**Step 2: Generate initial codes.** Data are systematically coded with short, descriptive labels highlighting key features. Initial coding identifies interesting and relevant segments.
Step 3: Search for themes. Codes are examined for connections or patterns and grouped to form potential themes.	**Step 4: Review themes.** Themes are reviewed and refined for coherence and relevance to the data and research question, ensuring accurate representation and alignment with research aim/s and objectives.
Step 5: Define and naming themes. Conducting a detailed analysis each theme is defined explaining its significance. Refinement and clarification of parameters occur, with assigned titles highlighting their essence.	**Step 6: Write-up.** Present the analysis in a written report, offering a coherent narrative outlining the relevant themes identified. Ensure a clear and nuanced understanding of the research question is drawn from the thematic analysis.

Braun and Clarke's (2006) 6-phase framework.

These 6 steps allow a flexible, iterative approach to thematic analysis as researchers can move between them dependent upon unfolding insights and evolving analysis. With application to my study and analytical approach:

In step 1, I collated my written field notes. Notes were studiously written and checked at the time with participants when possible and then typed up on the day of the interaction to ensure clarity and accuracy. Due to full-time work commitments this process often meant I worked into the early hours of the following morning. As I could not use a digital recording device the notes are not verbatim transcripts. They are, however, meticulously hand-written verbatim in the vernacular, capturing the essence of the interaction as it occurred, and drawn from memory which were enhanced by field notes and drawings. I then read and re-read all typed notes, revisiting participants at the earliest opportunities to gain clarity and ensure accuracy when necessary. At this early-stage ideas and potential themes were beginning to be generated,

pertaining to, for instance, recovery perspectives, the mundanity of everyday practice of people who use heroin within a rural setting, and regulated heroin use.

In step 2, I reviewed and familiarised myself with the data content and commenced initial coding (see appendix 9). I systematically assigned codes, initially focussing on any obvious meanings held in my data, concurrently crafting memos to explain my thinking and iteratively returning to revise codes as required to ensure equal attention had been paid to the data while engaging the evolving analytical process. I had three levels of codes: level one was participants' own words, level two developed categories and level three, was where the foundational elements of theoretical constructs began to materialise. I utilised the "constant comparative method" at this point, which is associated with Grounded Theory (Goulding, 2002), but which can be employed in the iterative process to effectively compare participant interviews, identify latent patterns in multiple participants' perspectives, and compare data in codes and themes (Glaser, 1965; Tesch, 1990; Fram, 2013). I systematically scrutinised the data to identify interesting and novel segments within my field notes, which incorporated notes from interviews, participant-observation, and nonparticipant observation. I was led by the data to decide where codes fitted within the thematic framework. Following this principle enables codes to evolve themselves and not be forced into pre-existing categories. This approach ensured my analysis was well grounded in the richness of the data, the coding process was "thorough, inclusive and comprehensive" as highlighted by Braun and Clark (2006 p36). By doing so highlights elements that reflected identified patterns, conveyed meaningful information, unexpected insights, or generally stood out. To complete the coding, I consulted Bogdan and Biklen (1997) for methodological guidance which prompted me to meticulously compile memos, and short, hand-written notes (on copious amounts of post-it notes) to identify my interaction with the data, subsequently I revised codes where necessary.

Following the coding process, I endeavoured to find and generate general themes from the assigned codes. In step 3, I commenced thematic grouping by placing similar codes together to form preliminary themes based on commonalities in the meaning and content. For example, I combined original codes on controlled heroin use, how heroin was used, and signs of chaotic heroin use to construct a preliminary theme centred on regulated heroin use (Appendix 9). Subsequently, I explored potential connections between codes and themes linking these to the previous themes while iteratively defining and refining them based on the dataset. This

recursive process not only facilitated the evolution or reassessment of initial thematic concepts identified in step 1 but also helped in the generation of new themes.

In Step 4, I reviewed and refined the identified themes, seeking those related to obvious meaning and those related to the hidden meaning. Throughout this process, again, I iteratively revisited the themes, ensuring a comprehensive and accurate analysis to faithfully reflect the dataset and by employing reflexivity, I aimed to enhance the credibility and trustworthiness of my analysis. At this stage, I also consolidated and eliminated certain themes. For instance, I initially had a set of preliminary themes centred around recovery, encompassing harm reduction, recovery-seeking behaviours, non-recovery behaviours, and recovery expectations (from the SDAS). However, I combined some themes while discarding others, resulting in a consolidated theme I initially entitled "Abstinence as a recovery pathway."

In step 5, I ensured a structured and logical presentation of my analysis which led to defining and identifying my three primary themes: (1) The absence of abstinence as a recovery pathway, (2) regulated heroin use, and (3) reliance on state benefits for income generation. This step allowed me to align the themes with the study's objectives, setting the stage for step 6, the write-up phase. This last step facilitated the contextualisation of the themes presented in chapters 6, 7 and 8 highlighting their interconnected nature and demonstrating my active role in the research process. Consequently, my themes align with my study objectives and research question, which aimed to investigate the everyday practices of people who use heroin in a rural setting and explore what recovery means to them.

I considered the process of "mapping out" which involved explaining relationships between the environment and sociocultural behaviours exhibited by the participants as suggested by Kutsche (1998). This process complemented Braun and Clarke's thematic analysis. Coding was continuous, exploring coding focus until no new information or themes were generated; a point termed "saturation" in thematic analysis where information becomes predictable and further iterations are of little or no value. Saturation is debated among scholars, with Braun and Clarke (2019a; 2019b) offering perspectives on its necessity to inform researchers. My data storage was organised chronologically and by participant using the software "NVivo 12 Pro", by QSR International (2018) which aided the coding process and facilitated further analysis. Additionally, the copious amounts of "post-it" notes that were used when identifying themes, despite their perceived archaic nature in a digital world, proved to be an invaluable asset.

I identified the conceptualisations generated from the thematic analysis. In doing so I facilitated the identification of what Saldana, (2011) regards as the *obvious* (or apparent) meanings of the data as well as *hidden* (or underlying) meanings. Within my data chapters my identified conceptualisations informed my themes and linked to my study aim and objectives, providing insight into the realities of the participants. Themes, themselves, represent the perceptions and experiences of participants which include but are not exclusive to individual or group behaviours, environmental aspects, emotions, activities, and verbal communications. Themes are usually described as topical (specific) or overarching (general), both essential for the conceptualisation of data and its link to theory. Identification of themes develop because of their significance or through their noted frequency within the findings, which leads to the development of patterns. Braun and Clarke (2021) highlight that this, however, does not warrant every pattern worthy of being labelled a theme or its inclusion in the data findings.

It was also important for me to consider information that had not become apparent from my findings and analysis. Instances where anticipated or expected data were notably absent offered valuable insights into my participants everyday practices. For instance, there was no evidence of public drug use, people resisted the opportunity to pursue abstinence, not everyone who used heroin sought support from SDAS and younger people who used drugs did not routinely use heroin. These observations, among others, warrant further investigation. Brewer (2000) contends that within the context of ethnographic research, researchers may find “some things are less true than others” (p.122), indicating that not all interpretations carry equal fidelity or accuracy. He argues that the researcher's responsibility is not to prove specific points, but to present data and findings grounded in truth. Consequently, this approach eschews notions of "right or wrong," fostering a nuanced understanding within the interpretative process.

In summary, I aligned with the perspectives of Whitehead (2005) and Van Maanen (2011) that ethnographic data analysis should commence alongside data collection, despite sometimes feeling overwhelmed by the sheer volume of data. I applied and adapted Braun and Clarke’s (2006) six steps thematic analysis framework and employed a reflexive approach to identify the main themes. Thematic analysis, recognised for its compatibility with qualitative methods like ethnography, was chosen as a methodological tool due to its straightforward yet robust analytical characteristics. A meticulous analytical process was undertaken with my data, involving Braun and Clarke’s steps of reading, re-reading, coding, categorising, and theming,

followed by interpretation and conceptualisation, thus adhering to the standards for ethnographic narrative analysis. Ensuring accuracy of analysis was paramount, as it forms the foundation of the trustworthiness and credibility of the entire field research. This rigorous approach ensures that my data will withstand scrutiny, reinforcing the reliability and accuracy of the interpretative outcomes. Detailed field notes were taken, incorporating descriptive language to prevent potential judgments while upholding "cultural relativism" as defined by Kawulich (2005). In presenting and explaining my analysed data, I wrote my notes using vernacular language, specifically the Scots language, to uphold the authenticity of participants' statements. However, capturing the nuances of Stranraer dialects proved challenging, necessitating translation to English. To maintain objectivity, I consistently practiced reflexivity by challenging and setting aside my preconceptions when writing field notes, and revisiting participants for clarification when necessary. Participant-observation and nonparticipant observation in the field were accompanied by interviews and notes detailing the physical environment, non-verbal communications, and participant behaviours, in line with Bishop's (1999) and Liukkonen and Åstedt-Kurki's (1994) perspectives, as elaborated within my analysis chapters.

5.10 Chapter conclusion.

In this chapter, I outlined the interpretivist methodologies employed in conducting my research of 51 people who use heroin (and 20 service professionals) in rural Scotland, aligning cohesively with my chosen theoretical framework. People who use heroin are often characterised as being marginalised, elusive, and a hard-to-reach community, particularly within an expansive rural setting. Identifying and selecting an ethnographic methodology was a strategic choice that offered me both the time and opportunity to trace and meet people who use heroin within a rural setting. The ethnographic approach provided a clear and systematic framework to explore my participants' everyday lives and practices through participant-observation, nonparticipant observation and interviews providing a window into their reality and a voice for my participants. Methodological reflexivity was also employed as a guiding principle to ensure a conscious and critical examination of my research project to maintain its integrity and rigor.

Snowball sampling initially employed for engaging with potential participants proved unproductive. SDAS staff, however, became instrumental gatekeepers by facilitating initial introductions to potential participants. In an unforeseen turn, the SDAS staff unexpectedly

contributed data themselves. Copious written field notes were generated from interactions within the field, capturing everyday narratives, environmental contexts and interactions with participants, and their wider communities. My study spanned one calendar year allowing me to immerse myself within the field. Both the data collection and analytical processes were strategically employed to reflect the everyday practices and realities of my participants. Methodological reflexivity was consistently employed throughout the analytic process, ensuring a critical stance throughout the analytical procedures. The objective of the analysis was aimed to present novel insight, deeper understanding, or provide fresh perspectives to existing literature, thereby enriching and advancing knowledge in this field. By articulating the analytical process and highlighting its value and significance clarifies the meaningful interpretation and analysis of my data and emphasises the distinct and innovative nature of my analytical approach. This highlights the contribution to the current body of research by employing ethnographic methodology to explore the everyday practices and mundanity of people who use heroin in rural Dumfries and Galloway.

In the following chapters, I introduce the study's participants and explore and apply the objectives outlined for my research. My focus is to chart the dynamics, tensions, and everyday practices surrounding heroin use and investigate what recovery means to people who actively use heroin within the rural setting of Dumfries and Galloway, within the context of the Scottish Drugs Policy; "*The Road to Recovery"* (2008-2018) (Scottish Government, 2008). By immersing myself into the nuances and intricacies of their daily lives, practices and realities, I generated and identified primary themes of the absence of abstinence as a recovery pathway, regulated heroin use, and reliance on state benefits for income generation. I begin by inviting you to meet two key informants: a co-habiting couple in a long-term relationship who live in a small, remote rural town and use and sell small quantities of heroin. We will explore their lives to unravel the challenges and opportunities that define their day-to-day lived reality within the context of their lived experience with heroin use.

Rush-hour in the Stewartry. Spring 2018.

Chapter 6: Exploring the acquisition, administration and financing of heroin use among people who use heroin within a rural setting.

6.1 Introduction.

On my last day in the field, amidst a cold January morning, I shared a moment with Deek, a 48-year-old key informant who has used heroin for over 30 years. As we parted ways on the street he shouted "Tell thum how it is fur me!" unwittingly epitomising my aim to serve as a voice for my study's participants.

In this chapter, I address my first objective: investigating how people who use heroin acquire, administer and finance their heroin use. To achieve this, I explore the everyday lives of people who use heroin within rural Dumfries and Galloway, presenting their daily experiences and drug-using careers. As outlined in the method chapter, I engaged in immersive interactions and interviews with 51 people who use heroin, (36 men and 15 women) and 20 health care specialists from the regions SDAS. Existing research indicates that people who use heroin predominantly focus on income generation to support their drug related needs. This routinely leads to society labelling them as deviant due to perceived criminal association (Hoffer, 2016; McKeganey, et al. 2009; Neale, et al. 2007; Bartlett, 2016; Best, et al. 2011; Doukas and Cullen, 2009; Hamersley and Reid, 2002; Gibson, et al. 2004; Glasser, 2012; McIntosh and McKeganey, 2000). Consequently, the actions, activities and behaviours of people who use heroin reinforce societal expectations and perceptions, positively determining and further reinforcing their role within this relationship (Stephens, 1991). Thus, my initial analysis focusses on activities related to income generation and drug-consuming activities as I expected these to be central priorities for people who use heroin.

My findings, however, revealed that people who use heroin in rural Dumfries and Galloway, often under the influence of methadone and "street" benzodiazepines in addition to heroin, face routine, mundane and unique challenges. These challenges extend beyond heroin and other drug use, and encompassed the routine demands of everyday life. Contrary to commonly held stereotypes, they did not hide away only to appear to access heroin and generate income; they engaged fully within their communities participating in mundane and routine tasks familiar to people who do not report illicit drug use. These initial findings challenge contemporary and historical negative constructs of people who use heroin, aligning with McKeganey, et al.'s (2009, p.247) findings that there are "people who appear able to consume heroin without

experiencing many of the problems (associated with heroin use)" and Neale, et al.'s (2007, p.232) assertion that people who use heroin lead "ordinary lives". I found my data conclusively demonstrate that people who use heroin, like those who do not report illicit drug use, live integrated, structured and largely conventional lives, despite the backdrop of Scotland's public health drugs crisis linked to drug related deaths. I start my analysis by examining drug-consuming activities.

6.2 The everyday practices of people who have experience of heroin use in rural Dumfries and Galloway.

To gain insight into the everyday lives and experiences of people who use heroin in a rural setting, it is necessary to understand their identities. I want to consider why actors with spoiled identities (Goffman, 1963) and entangled identities (Gibson, et al. 2004), may actively pursue anonymity. Presumably, seeking anonymity is a protective means of avoiding detection by the criminal justice service and people who do not report illicit substance use. In doing so, however, they arouse suspicions and public fear about heroin and people who use it as detailed by scholars such as Perretti-Watel, (2003) and Carnwath and Smith, (2003). These concerns underpin and reinforce prevailing dominant symbolic and contemporary negative values associated with heroin, its use and those people who use it (Schiebe, et al. 2017).

People who use heroin are noted to live at the margins of society and are notoriously difficult to find and maintain contact with, especially in rural settings. This is due to their perceived low numbers and expansive geographical spread. Estimates, however, demonstrate that heroin use is at comparable levels per capita within rural and urban areas in Scotland (Scottish Government, 2018). Regardless of heroin use, people who use heroin like their non-using counterparts must meet their everyday needs (in addition to sourcing and using heroin) within their respective communities. The everyday lives of participant's who used heroin, however, were found to be predominantly uneventful. They were discrete and remained inconspicuous when fulfilling heroin-consuming activities and income generation where there was little change to their everyday practices. Their conscious efforts to avoid undue attention partially explain why their heroin careers and how they address recovery tend to go unnoticed and underreported.

6.3 People who use heroin in Dumfries and Galloway.

The 51 participants in my study provided specific demographic information and data relating to heroin use and recovery within rural Scotland. My data revealed an older demographic of people who use heroin within the region, with an average age of 39 for men and 35 for women. This is comparable with studies by Bernstein, et al. (2005), Beynon, (2009), Nahata, et al. (2018) and Ng, et al. (2019), but 10 years older than the mean age of 29 for people who use heroin within the U.K. (EMCDDA, 2019). Despite a decline in heroin use, as with the rest of Scotland, there has been a steady increase of heroin-related deaths within the Dumfries and Galloway. The participants in my study reported chronic yet stable heroin careers that commonly began in their late teens. The participants were a relatively homogenous group, consisting mainly of white Europeans. This contrasts with the heterogeneous populations of people who use heroin routinely found in urban areas, which are often the focus for research, consequently used to inform policy across both urban and rural settings.

My data revealed a male-to-female ratio of 36 (71%) men, and 15 (29%) women, comparable to studies carried out by urban researchers such as Stein, et al. (2017) in San Francisco (433 urban people who use heroin), Bernstein, et al.'s (2005), in Boston (1175 people who use heroin and cocaine), and Zhou, et al.'s (2017) in urban China (788 people who use heroin). Notably, U.S. studies on heroin use tend to report higher numbers of ethnic minorities, representing diverse heterogenic cultures that urban settings often attract. In contrast, Chinese society, with its insular nature and restricted immigration, reflects its urban homogeneity. An SDAS community outreach worker I met felt the gender ratio to be incorrect, insisting there was an equal gender representation throughout rural Dumfries and Galloway's community of people who used heroin:

> "Ers as many women, if no mare, as men thit yase, jist the women hide and dinnae engage wi' services cos they dinnae want the weans taken in tae care….so they urnae coonted in the numbers" (John, outreach worker).

His assertion resonated with Beardsley, et al.'s (2003), and Zhou, et al.'s (2017) findings suggesting that women are less likely to change their drug using lifestyles by engaging with services and potential recovery pathways if they have children. Children of mothers who use heroin (not fathers unless they are the main carers) within the region are automatically considered "at risk" and are subject to potential removal to a place of "safety" by local

authorities. John explained that he felt many of these mothers miss potential benefits for change offered by recovery services, such as methadone and access to financial benefits, despite, "being mare likely tae engage with thum (recovery services) as they huv weans (recovery capital) fur motivation".

SDAS staff clarified that mothers, to keep their children from local authority care, would not engage with recovery services at any level. SDAS staff routinely noted that mothers who used heroin within the region consistently prioritise their children's well-being before their own recovery opportunities. This presents an anomaly: children are key motivators for change in the women's lives to reduce and potentially stop their drug use, (children could arguably be consider recovery capital), but the risk of losing their children to social services discourages women from participating with recovery services and the prospect of engaging with change. Consequently, SDAS staff voiced their concerns regarding the vulnerability of mothers who use heroin. They expressed the women could be at risk of exploitation and extortion by men threatening to expose their heroin use to authorities, using this knowledge as a fulcrum to control the women financially and even sexually.

Gender and place dynamics then, pose challenges for the formulation and development of effective intervention strategies. Smith (2014) identifies "a lack of anonymity and a culture of rural watchfulness, means that many women, fearing for their reputation and the reputation of the area, will not help-seek" (p523). My data demonstrated the predominant concern among women is the potential loss of custody of their children to social services. Concerns with "rural watchfulness" are mitigated by a supportive community, comprised of people who do and do not use drugs, who are aware of the women's substance use disorders. Despite this awareness they remain protective and inclusive toward them and their children. Somewhat paradoxically, this supportive and inclusive environment may inadvertently dissuade women from changing and seeking help. Neither the fear of losing children nor the criminal justice system dissuaded illicit drug use. These factors combined with gendered performativity, rural spatiality and a reluctance to relocate, collectively discourage women from pursuing recovery-focussed interventions or changing their drug use behaviours.

All but one of the women who participated in my study had had their children removed from their care by the region's authorities. Subsequently, these women actively engaged with

recovery services for several reasons following the removal of their children. Firstly, to gain access to and maintain supervised physical contact with their children. Secondly, they aimed to demonstrate their ability to engage with services and demonstrate that they can change their drug using behaviours, thereby increasing their chance of having their children returned to their care permanently. Thirdly, they sought a methadone prescription, explaining that it, along with heroin, helped ease the emotional pain and distress resulting from their children's absence. The continued use of heroin, however, perpetuated their situation and negated any possibility of them regaining custody of their children. Notably, these women did not self-identify as "bad mothers" or "junkies". They asserted that their children were loved, wanted and had been well cared for, points supported by SDAS staff who were privy to case details. This perspective aligns with the recognition of the potential recovery capital that children represent while identifying rationales for increased and ongoing drug use.

During my fieldwork, I recorded two instances where women, not engaged with recovery services (relayed through a third party who supplied them with drugs), expressed apprehension about meeting me. As mothers who used heroin with young children, they feared potential interventions by local authorities if they made themselves known to me. Literature supports their belief, indicating mothers with heroin use experience, face higher levels of stigma within their communities with their constructs underpinned by negative perceptions of heroin use and deemed "bad mothers" (Ettorre, 1992; Taylor, 1994; Lean, et al. 2013; Sharpe, 2015). However, participants in my study, including SDAS staff, provided a quite distinct perspective. They identified mothers who used heroin as being protective of their children, emphasising and underpinning the need for these mothers to be well-organised, discreet and regulated in their heroin use to remain "hidden" within their rural communities. This strategic approach to heroin use and motherhood helps maintain a healthy distance from authorities whilst allowing the mothers to care for their children.

Billy, a key informant, revealed that in his experience, his local community rejected the notion of people who use heroin as "bad parents":

> "Aye ma boy is nearly 18, aw his pals come roond here, 'ers a big bunch ae thum, cos they like the banter…..an' the lassies love 'im, don't they son? (Winks at his son)…a cannae keep up wi awe his girlfriends. He kens aboot ma addiction, a dinnae hide it fae

> ‘um dae a son? (Son acknowledges affirmatively). And his pal's ken as well but they dinnae let it affect thum” (Billy, aged 59 addressing his son, aged 17).

Billy used heroin, methadone and alcohol daily, yet paradoxically, possessed significant recovery capital. He was a husband of 30 years, a father to two sons (17 and 29), and he owned his own home. Despite being a “major dealer,” in the area he identified as a “heroin addict”, never a “junkie”, but only using the label of “heroin addict” to access methadone from the SDAS and benefits. His younger son made his views clear that he did not like his father using heroin but also expressed understanding of why Billy did it. Billy was clear that he had no intentions of changing his drug using practices. Remarkably there was openness between them, which I observed extended to his son’s friends, who were aware of Billy’s heroin use. Surprisingly, this did not appear to negatively impact his son’s large group of friends, many of whom were regular visitors to their home. Billy’s heroin use was, to some extent, mitigated by his wife who does not use illicit substances. This arrangement ensured the “children” had a responsible carer which had kept them from being removed to local authority care when they were younger. While Billy’s wife worked 9-5, Monday to Friday in a professional healthcare role, Billy had been the children’s main carer throughout their formative years.

Women who used heroin lacked this safeguard:

> “A wis worried thit naebody wid turn up for the weans perty, everybody kens who a um and what a dae…they awe ken……..A invited aw the kids fae his class (n21)….aw the parents dae whenever it’s their weans birthday. (Long pause)… An’ awe thum turned up….. apert fae yin but they hud been oaf sick an’ his Dad came roond wi a caird and present and tae say sorry. Bit the wean wis roond the next week his-sel’ fur tea. Apairt fae that it wis jist like ony other perty, they dropped the weans off and picked thum up later” (Melissa A, aged 27).

Although Melissa A engaged in frequent heroin use, she exhibited a very specific, regulated and controlled approach, meticulously managing the timing and quantity. She strategically used the minimum she could, changing her drug use routine so she could do so at the furthest point of contact between recovery services visits when she had to provide a urine sample for analysis. A positive screen for heroin could potentially lead to both her young children being placed in care of the local authorities. Regardless, Melissa A did not want to stop her heroin

use, she wanted to use more in a controlled fashion, she expressed she was a good mother, and her children were well cared for. She was well-known in her small town not only because she had been raised there, but also from a past prosecution, reported in the local newspaper, when she was found in possession of heroin several years earlier and prior to her children being born.

> "Most of my kids [seven in total] are with my family members and I see them daily. We all live close to each other [in a small town]. Two are with foster carers in the next town, [25 miles away] I see them most weekends. Everybody knows what's happened. They all know I do heroin, but they don't give me or the kids a hard time. They still get invited to friends' houses for tea and their friends come over to mine. I went to school with their parents and most of them are [non-drug-using] friends of mine…. it's fine" (Bonnie, aged 36). (Translated to English from the Stranraer dialect).

Bonnie used heroin daily, however, she skilfully maintained regular contact with all her children relying on familial ties and bonds for their care needs. She regulated her heroin use and associated activities to ensure she played a pivotal role as a mother in her children's lives. She was very charismatic, never spoke of her partner and was very astute with regards to her legal status about her access rights to her children. She was also well known and respected within her community, despite her known association with drug use. Bonnie's everyday life and practices resonated with notions of recovery and recovery capital, including regulated heroin use, close familial contacts, community support and inclusion, engagement with SDAS for methadone, and a firm rejection of a spoiled identity. She did not problematise heroin use and had no intention of stopping or changing her drug use. While she embodied a typical profile of people who use heroin within the region, Bonnie uniquely and successfully retained contact with her children, with the younger children cared for by family members and those over 16 residing with Bonnie.

6.4 People who use drugs? People who sell drugs? Something in-between?

As with Hoffer's (2016) three-year study conducted in urban Cleveland, the U.S., investigating 38 people who used heroin through participant-observation, my research in rural Dumfries and Galloway revealed participants engaged both in regular heroin use and its sale. Hoffer found that the dynamic interchanges between drug use and sales are influenced by three factors: their heroin needs, heroin availability and their financial status, patterns also generated in my findings. This, however, contrasts with the conventional characterisation of distinct roles

between people who sell drugs and people who use them (Bourgois and Schonberg, 2009; Hoffer, 2016). Dumfries and Galloway had an estimated population of 1,500 people who used heroin in 2018 (Scottish Government (2019), representing 1% of the region's population and reflective of heroin use throughout the rest of Scotland. Participants routinely reported they relied on "poor quality" heroin, challenging the conventional urban "dealer-user" model and a product that does not entice new clientele:

> "It's no like the big toons or cities doon here….ers simply no the numbers [people who use heroin] and they ur scattered aw ower the place…it's a cottage industry [laughs], dinnae git me wrang it peys fur ma needs bit a dinnae drive a beemer (BMW)" (Billy, aged 59).

> "A dinnae make a lot ae money jist enough tae keep me tickin' ower, pey fur ma gear an' the cost o' getting' it…maist ae ma customers ur fae here an' CD (neighbouring small town) a buy whit a can afford, use what a need and sell the rest, jist tae people a know" (Ashleigh, aged 28).

> "A jist huv ma regulars…a make enough tae tide me ower fur ma ane needs…..an' am no exactly livin' in fuckin' Buckingham Palace um a?" [Laughs]. (Nikki, aged 37). Lived in a one-bedroom ground floor social housing flat in a small rural town.

> "A sell tae people a know….only people a know…. A live wi my Ma so a cannae gaun daft …a dinnae want any attention fae the polis so a dae enough tae keep us tickin' ower" (Wullie, aged 42 - main carer for disabled mother, lives in a small town in the west of the region).

Participants routinely stated they used and sold drugs, but it became apparent within my findings that there were distinct variations amongst them. Notable individuals such as Billy, Nikki and Ashleigh, for instance, sold more heroin than they used. To capture these differences, I broadly categorised sellers into three distinct levels (outlined in table 1). My categorisations were formed from the quantities of heroin sold and used, and how well they were known and regarded by other people who used drugs within their communities.

Table 1: Classification of people who use and sell drugs in the study area.

Level/numbers	Sell to	Heroin amount and approximate outlay	Purchased from
People who use drugs /low-level people who sell drugs (all participants).	Family members, friends, and acquaintances. Occasionally strangers at inflated prices.	1-5 (.1g) wraps = £10 to £50.	Medium-level people who sell drugs and other people who use drugs.
People who use drugs /medium level people who sell drugs (approx. 10-15 participants).	Acquaintances who use heroin, family, and friends.	50-500 wraps (.1g/.4g) = £250 to £2,500.	High-level people who sell drugs within or outside the region (Newcastle, Glasgow). Purchasing drugs outside the region had associated risks (violence, robbery, police).
People who use drugs /high-level people who sell drugs (3 participants).	Medium-level people who sell or use drugs, specific low-level people who use drugs, family, friends, and acquaintances.	Heroin is bought in multiple grams for (?cutting), packaging and distribution. £5,000 to £15,000.	Organised criminal gangs in Glasgow, Paisley, Carlisle and Amsterdam.

I found that people who sold drugs and those who used drugs displayed genuine concern and compassion for each other's well-being. They offered support in times of adversity and need which often led to and cemented friendships. This suggests a shared experience of heroin use creates social connections and friendship underpinned by a sense of mutual understanding pertaining to their specific set of circumstances and challenges. The overdose crisis in Scotland serves as a poignant example, overdose deaths had more than doubled in the region within the previous decade, mirroring the trend of drug related deaths throughout Scotland. Overdose was a routine risk highlighted by participants, often centred around lone drug use, which I demonstrate throughout the following chapters. The rural setting of the region arguably increases the likelihood of overdose due to poor telecommunication connectivity, poor transport infrastructure, and expansive geography leading to lone heroin use.

The ability to save a person's life by administering naloxone, providing CPR and engaging emergency services places a significant responsibility on any potential life saver. When this responsibility is taken on by people who use or sell heroin, it exemplifies a clear demonstration of care and commitment by them. Naturally, such actions invariably engender trust, particularly when undertaken from a position of vulnerability by the individual whose life is threatened

especially where it is administered by an individual who uses heroin. This not only acts to strengthen the bonds of friendship and trust between them but arguably extends to the broader drug-using community. It creates a shared narrative of survival and shared vulnerability, emphasising a collective resilience and support within this community. It perhaps opens recovery pathways to change where an individual has a near death experience or reaches "rock bottom", equally it may act as a barrier to change and recovery as it reinforces "negative recovery capital", where individuals feel connected, included and safe amongst their drug using peers.

This, however, stands in stark contrast to studies by Hoffer (2016) and Preble and Casey (1969), which portrayed people who sell drugs as violent, uncaring, cold and hostile, primarily focused on the "deal" and financial rewards. Contrary to these characterisations, I routinely identified instances in my data where people who sold drugs actively helped those using them. For example:

> "When Siobhan came tae me fur gear she wis in a bad way…she wis fucked and she wis gonna end up couping [overdosing]. A gote her an emergency appointment wi Cameron Hoose (SDAS) and took her through tae Dumfries in a taxi tae git her sorted wi a script [methadone] so she could see her weans and git herself soarted" (Scott, aged 37).

> "A dinnae sell tae weans bit a seen this lassie a ken she's 18 or 19 or sumhin….an' she wis tryin' tae sell tae a 16 or 17 year auld and a shouts' "Hi ya fuckin' wee cunt dinnae be sellin' tae weans or a will make share yer Maw kens", she's yin ae mine [customer]. Then a says tae the wean tae git tae fuck or yi'll end up like me…then a recognised whay she wis and a sais a'll tell yer Ma yer tryin' tae buy gear….she says she wisnae bit a wisnae takin' any chances" (Nikki, aged 37).

> "A fuckin' couped again….it wis right gid stuff fur a chinge…nixt 'hing am starin' it a paramedic. Ma dealer phoned 999 when a went ower [overdosed], saved ma life, he's a gid cunt (Charlie, aged 54).

> "He's [person who sold drugs] gid tae us like…..when am waitin' fur payday [benefits money] he sees me alright [provides heroin] an' a pey 'im back……bit a owed a couple

> ae pals an' ma Ma [mother] money an' a hud tae pey thum first and they [authorities] chinged ma benefits wi oot me kenin' so a wis fucked like. A hud tae pey thum cos a owed them it fur ages an' a nivir hud enough tae pey the man [person who sold drugs] so a went tae tell um an' a wis pure shitin' masel, so a took ma telly [black and white portable] an some cans ae soup a hud fae the foodbank….collateral likes, till a gote masel sorted. Bit he wis like naw jist keep the stuff an' he gave us some gear tae keep us goin' then a wis walkin' awey and he shouts us back and a thought he wis gonna chinge his mind and gies a kickin' but he gave us a 10 [pounds] tae sees us through. Fuckin' sound or what?" (James, aged 38).

This section generated common themes regarding the "identity" of people who use heroin, some of which were similar to those Smith (2014) found in her study of drug-using women in rural Wales. People who used heroin commonly self-identified as parents, partners, employees, and friends in their everyday lives, occasionally as "drug users", infrequently as "addicts", but never "junkies." They did not perceive their identities as "spoiled" or needing of "fixing" despite their drug careers. The presence of recovery capital was constant and evident in the form of familial and friendship bonds, a sense of inclusiveness and trust between people who used heroin, availability of the SDAS, carrying naloxone and training in its use and inclusion by people who did not use drugs in their communities. Everyday practices associated with heroin use reflected and demonstrated both mortality and compassion for other people. Heroin was routinely observed as being regulated contributing to stability in the lives my participants and its use was not problematised, despite the presence of associated harm indicators. As Smith found performativity and spatiality may be a barrier to change and recovery when people who used heroin played central roles within their drug-using social groups, which were, in the main, rich and supportive. The prospect of change through a recovery pathway may be perceived as daunting, as it could compromise their existing roles without assurance of a new identity, role, or inclusion within wider society.

Heroin had a significant role in bonding and cementing relationships and forging friendships amongst people who use heroin arguably, reinforcing its use and their bonds. Within the initial stages of my fieldwork, it quickly became apparent there was a notable lack of anonymity for people living throughout the region. People who used heroin were not only known to people who did not use drugs, but they were also recognised by people who used and sold drugs, creating challenging or as reported on several occasions by participants, an "impossible"

situation to escape from. People who used heroin, however, did not want to leave the region due to familial ties, friendship and feelings of spatial performativity, similar factors identified by Smith (2014) in her study of "heroin users" in rural Wales. Neither did they seek abstinence, which was categorically rejected by all my participants and not expected by recovery services. This, somewhat paradoxically perhaps, reinforced heroin use and increased the likelihood of associated harm indicators such as overdose and health related problems.

6.5 The market: Availability of heroin in rural Dumfries and Galloway.

A pivotal consumer activity for people who use heroin is the acquisition of heroin. The ability to source and procure heroin is central to that person's very "being". Glasgow City, for example, is a compact geographical space where 12,000 people are estimated to use heroin, creating a constant demand for a reliable supply of heroin and a sound economic argument for trafficking it (NRS, 2019). Rural dynamics, however, are notably different.

The amount of heroin in circulation within Dumfries and Galloway is unknown due to its illicit nature. Indicators, such as 1,198 recorded crimes for possession of illicit drugs (all drugs) and 144 for possession with intent to supply, totalling 1342 incidents in 2018, do offer some insight into the regions drug-related activities and impact (Scottish Government 2020). Statistics do not categorise drugs or individuals involved, which may reflect repeat offending with heroin not being involved. Statistics also indicate an active criminal justice service within the region, which people who use heroin dynamically seek to avoid. Some participants cite them as obstacles to recovery and recovery capital a point I will elaborate on later. Notably, there were 20 drug-related deaths in the region throughout 2018, an increase from nine in 2008, when *The Road to Recovery* strategy was introduced. Toxicology reports recorded that each victim had used at least two illicit and licit drugs excluding alcohol. SDAS staff asserted that drug-related deaths were increasing among traditionally chronic but stable people who used heroin, attributing this trend to the availability and use of cheap "street" benzodiazepines.

Given the following facts - Dumfries and Galloway's expansive geographic area, the classification of heroin as a Class A illegal drug, and the deviant nature associated with people who use heroin (Allen and Alberici, 2018; Moraes, 2001; The Scottish Government 2008), I anticipated a low (estimated) number of people using heroin and correspondingly low prevalence of heroin availability. My expectations aligned with Robins' (1993) quantitative study of U.S. Vietnam veterans, which demonstrated a high correlation between heroin

availability and use: a simple case of supply and demand. Low and sporadic heroin availability may potentially positively affect recovery behaviours, bolstered by available recovery capital, such as the regions recovery services, housing and financial benefits, all of which were readily available at no cost. Where heroin supply is uncertain, fear of withdrawals may drive people to engage with recovery services and promote change in their behaviours, a phenomenon highlighted by the U.S. Department of Health (2016) may not happen where heroin is prevalent, attainable and affordable.

Contrary to my expectations, my findings indicate heroin was consistently and widely available. Participants were routinely observed accessing and using heroin even in the most remote areas of Dumfries and Galloway. My observations align with assertions made by Jones, et al. (2015), Evans et al. (2019) and The Recovery Research Institute (2019), that heroin is readily available and accessible. The findings from Moyle and Coomber's, (2015) study that heroin is generally widely available is corroborated and reflected in my findings:

> "Fuck aye, a kin git it whin iver…yi kin git anyhin' yi want roond here" (Nikki, aged 37).

> "Night or day….jist a phone call away [laughs]" (Brian, aged 29).

> "To be honest it's too easy [to get]….yi cannae get away fae it, y'know" (Louise, aged 39).

> "Yes, tell me what you would like, and I can telephone and get it for you just now, would you like it delivered?" (Bonnie, aged 36).

> "Martini!…..anytime…any place….anywhere" (sings Harold, aged 46).

> "Even when yi dinnae want it …people will come roond an' offer it tae yi it's impossible tae git away fae" (Deek, aged 48).

> "Even 'ere, int' middle o' fuckin' nowhere's in this shit 'ole one 'orse town a kin go now n' git a few wraps if needed" (Dan, aged 38).

Dan relocated from a large city in Yorkshire to a small coastal fishing village in the region to live with his parents. His motivation was to escape his friends who used heroin and achieve abstinence from it. His move was initiated following the death of his partner and his own near-death experience both due to heroin overdoses. Dan's father, who provided recovery capital in the form of financial and emotional support, had issued an ultimatum: "Stop drugs or am washin' 'ands of ya'". Dan's father believed Dumfries and Galloway to be safe and "away from drugs" due to its rural setting, prompting Dan to move to Scotland to be with his parents and "start afresh" by changing his everyday practices, engaging with harm reduction interventions such as methadone to become abstinent and subsequently losing his drug using identity.

Dan, however, never stopped using heroin:

> "As soon as a stepped off t'bus in Dumfries, a scored…in twenny minutes, a saw bloke on t'bridge in town an' says got owt? Aye, what yi want? He says, and that were it, sorted like".

Dan's parents owned a large house, situated 500 metres from the beach, with a large garden, and a stunning panoramic view of the Solway's clear turquoise blue sea, it was where he used heroin and occasionally sold drugs. Dan's vista stands in stark contrast to Stewart's (1996, p.88) assertion that "scoring can be a miserable business and often involves going to soulless housing estates or smouldering slums." His parents were blithely unaware of his drug use, believing him to be heroin-free but on a methadone prescription. Dan, as an active "heroin user", expressed that recovery meant nothing to him. He asserted that the SDAS coerced him into claiming he was in recovery to access methadone a charade he maintained for his parents. Despite possessing recovery capital such as supportive parents who saved him when he hit "rock bottom", financial stability, a home, and a strong social network, Dan exhibited no inclination to transition towards a more constructive and less harmful drug free lifestyle. He argued against the necessity for his life to improve or become more fulfilling, as he claimed to be living his best available life. He was adamant that relocating back to York would not enhance his life, but dismissed local opportunities such as joining community groups or reclaiming responsibility for household chores that his mother completed for him that would arguably enhance his recovery prospects. Additionally, he showed no interest in adjusting his methadone regime to decrease his heroin use. Dan resisted any opportunity to embrace sobriety and become a contributing member of society, instead focusing on advancing his "identity" as

a level 2 person who sells drugs and claiming his own "patch" for drug distribution. Given his entrenched perspective and motivations, Dan challenged any idea for change despite the inherent risk to his well-being and family relations that his drug use brought.

Participants from around the region explained that heroin was regularly trafficked into the region's larger towns from northern England, Glasgow, and Paisley. This transportation predominantly occurred via public transport because couriers could quickly and easily disassociate themselves from their illicit contraband in the event of police scrutiny. Public transport (albeit slow and at times unreliable) was in turn a conduit for distributing heroin throughout the region, which Coomber, (1999) noted as the customary practice among those who sell drugs in the U.S. A level 2 person who sold drugs explained:

> "A take the bus when am cairryin', that wiy a kin jist drop any gear oan the flair if the polis come oan the bus…they cannae prove its mine" (Ashleigh, aged 28).

I found during my data collection that using public transport over private transport (considered a necessity by many living in rural settings and arguably essential recovery capital) was given priority by people who use heroin to avoid detection by the authorities, thus challenging Saleme et al.'s (2018, p.23) findings, that "drug-dependent individuals tend to take more risks than non-drug users."

People who sold heroin based in England close to the border of Dumfries and Galloway were especially risk-averse to crossing the border into Scotland. Their reluctance was due to concerns about being apprehended by the police and subsequently a custodial sentencing by the Scottish criminal justice service. In contrast to English courts which send convicted individuals to prisons close to where they live to maintain familial and community links, a custodial sentence in Scotland meant incarceration in a prison <u>anywhere</u> in the country. This led to reduced visitation by friends and family due to the increased distances for travel.

> "You can go down Carlisle ont' bus and score but they (people who sell heroin) don't come over border in case rozzers nick and jail 'em up 'ere…they end up in Glasgow, Aber-fuckin'-deen [250 miles] or summit, they [judiciary] do it on purpose" (Mark, aged 28).

The availability of heroin and the connections between people who used heroin identified in this section appear to be negatively associated with recovery. Recovery and social capital were clear in my findings; however, the social connectedness facilitated by this capital was most often associated with people who used drugs. Thus, many of the associated advantages, such as friendship and support were intertwined with drugs and their use. Consequently, the social connectedness brought about by social capital perpetuated a cycle where it was used to procure, acquire and use heroin. This cycle had the effect of maintaining a core and stable group of people who used heroin with little motivation for change. This demonstrates a complexity between substance use and, in this case, social capital and the effect it had on establishing enduring social groups among those people who used drugs.

The "community" of people who use heroin was also intrinsically interconnected, often by a sense of entrapment as expressed by Louise who stated "escape wis impossible." Many of the people who used drugs found securing anonymity from friends and acquaintances with heroin use experience challenging and would routinely seek each other out. Furthermore, participants noted that prices and quality of heroin have remained stable over the past decade, this contributed to a negative association with heroin use and recovery despite the availability of immediate recovery capital from the SDAS. I found during my data collection that participants indicated that heroin was simply "too easy" to procure. People who used heroin such as Dan and his non-drug-using father who believed the rural nature of the region would make it an unlikely place to source heroin were proven wrong.

My findings indicated that contrary to common perceptions of risk-taking behaviours, many people who used heroin demonstrated careful, introspective, and cautious approaches to heroin use and trafficking, despite its ready availability and having the financial means to purchase it. This aligns with McKeganey et al.'s (2009) findings on unproblematic drug use. Curiously, despite its constant supply, stable cost and purity, heroin use and the numbers using it were steadily decreasing within Dumfries and Galloway. This trend was noted both by my participants and SDAS staff alike. While traditionally chronic and stable people who use heroin continued their heroin use, there was also a notable increase in their use of inexpensive "street" benzodiazepines and free prescription methadone. The combination of heroin, methadone and street benzodiazepines was routinely reported in toxicology reports to the SDAS following deaths from overdose within the region, which had increased over the previous decade. Alcohol was also a constant. Polysubstance use led to an increased mortality rate among people who

used heroin and partially explains the decline of heroin use within the region, as younger people shunned heroin in favour of "street" benzodiazepines and recreational drugs. However, this situation reflects the interconnectedness within the community of people who use and supply drugs, prompting the question about other factors contributing to the decline of heroin use within the region. Could this be attributed to *The Road to Recovery* strategy, or did recovery capital have a role?

6.6 Acquisition of heroin within rurality.

Although prevalent within Dumfries and Galloway, heroin's illegal and illicit nature prevents its open sale. A logistical challenge then arises: how do people who use drugs acquire heroin in such a vast geographic area, and does this logistical obstacle have any bearing on the decline in heroin use, everyday practices, related harm indicators or impact recovery pathways? As previously demonstrated, my findings revealed that acquiring heroin was reported as straightforward for participants, as they were "known". People who used heroin would readily source and purchase "gear" from friends, acquaintances, family members and others involved in heroin use. The following is a comprehensive overview compiled from participants from throughout the region:

> "A git it oaf a mate," Charlie, (aged, 54).
>
> "Pals maistley…an' ma brutha," (Neil, aged 37).
>
> "People a know….in the toon" (Steven, aged 43).
>
> "Ma maw drives us in (to the local village) n' a git it oaf a mate it his hoose" (Josh, aged 23).
>
> "Ooh, I have it delivered to the door, saves me going out" (Angela, aged 45).

Angela resides in a small town of 4,000 people to the east of the region. Her narrative placed acquiring heroin on a par with ordering takeaway food. Using her mobile phone, she placed orders, with transactions typically costing £10 for .1g or her preferred .4g wraps, at £20. Technology was commonly employed for payments, often preferred to cash by both people who used drugs and those who sold them. Platforms such as Facebook, PayPal and debit cards

were widely used and accepted for heroin purchases. Angela, who opted for discretion and convenience, paid in advance via PayPal for her .4g wraps "just a couple of times a week." The deliveries were posted through her letterbox within 10 minutes of her ordering. This approach eliminated any need for her to meet the "runner" or hand over cash, ensuring a covert and trouble-free transaction. Angela knew and trusted the person she bought heroin from, she referred to them as her "friend", explaining their relationship stemmed from school and shared upbringing in the same town, a recurring theme throughout my findings. Angela explained that her life was "peachy", although she had to "put on a show" for SDAS to ensure her continued access to her daily methadone script of 15mls but had no intentions of changing her life to become drug free.

The "community" of people who use heroin in Dumfries and Galloway, reflecting similarities to Stephens' (1985) findings, were close-knit. They knew and trusted one another, mirroring Hoffers, (2016) study, which revealed a close and shared camaraderie and interdependency among those who use heroin. This manifested in mutual trust, reliance and long-term friendships often spanning decades, aligning with Redlinger's (1975, p.331) identification of people who use heroin as a network, involving "friendships, relations, constraints and crisis" a reflection evident in my findings. I observed that payments for heroin between friends and known acquaintances were commonly deferred or reciprocated later, highlighting shared necessity for continuous access to heroin and avoidance of withdrawal symptoms:

> "A widnae see anybody withoot…a ken whit it's like tae rattle an' if yi didnae gie somebody a wrap it wid be ma luck tae be rattlin' when they hud gear [laughs], they always pey up or gie yi stuff in return anywey" (Nikki, aged 37 level two person who sells heroin).

> "A dinnae pey fur benzo's that's no' how it works. If a huv somethin' a share it an' if they huv somethin' they share, like offerin' a tab (cigarette), know? If a huv gear a sell it fur whit a pey or gie in place ae the benzos….bit a widnae see a mate gaun wi' oot an' likewise if am no well [withdrawing] a ken they will gi' us somethin' tae tide us oor, know? (Paul, aged 42).

The more rural the area in Dumfries and Galloway, the more insular the "community" of people who used heroin became, making it increasingly difficult for "outsiders" to establish initial

connections for purchasing heroin. Dan, an outsider from York, however, sourced his first heroin purchase without issue in Dumfries by approaching someone in the street he believed used heroin: "'t were way he looked." Dan struggled to articulate the specific characteristics of the "look" other than to say as a person who uses heroin he can "just tell" when someone else uses heroin or drugs. In the more rural communities, an "outsider" who uses heroin required someone to vouch for them or buy heroin on their behalf, with the "middle person" receiving a share of the purchase. Outsiders had to wait until they became "known" within their locale before being able to directly purchase heroin from someone who sold it, gaining the fraternity of people who used heroin. Consequently, this unintentionally positively impacted on outsiders' access to SDAS recovery services enforcing change as they sought to source methadone, it also encouraged the use of other more accessible drugs such as benzodiazepines or alcohol to get "high" and stave off withdrawal symptoms.

Becoming "known" meant residing within and interacting with the broader community, not just the heroin community. Information about the individual, like outsiders who did not use drugs, would circulate and filter through to the person who sells heroin, reaching them through their connections among acquaintances, neighbours, friends, and family:

> "You wouldn't be able to buy gear here….yer no a kent face, but neither wid anybody fae the next toon. If a dinnae ken them they git fuck all, simple as.... and a huv the best stuff, no like the shite along the road [next village 25 miles away]. If a selt stuff and they (the purchaser) gave it tae thum… different matter, bit a huv tae ken first or they git fuck all again, and they can pitch up at Cameron Hoose's [SDAS] door, that wey a ken where it's goin' and whae it gaun's tae. It's a wee place and everybody kens evirbody, a wis brought up here and a ken everybody and they ken me and whit a um, so a ken whaes whae and whats goin' oan. Last thing a need is tae be done ower by the polis…. it wid upset my Ma", Wullie, aged 42 [Wullie's mother, aged 77, was physically infirm due to a stroke, he was her sole carer, his 3 older non-drug-using siblings devolved all her care to him].

Wullie resides in a small town of 3,500 people, where he, like his parents and extended family, was born and raised. He carefully vets and screens his customers, who he calls "friends", selling small quantities of "higher purity" heroin at regular prices ensuring customer loyalty. Wullie is careful not to draw attention to himself as an individual who both uses and sells heroin,

especially from people who did not use drugs in his community with whom he interacts daily and elicits information about others. Wullie had been imprisoned previously for selling drugs (Cannabis, which he had cultivated in a nearby town), which is known about in his local area, and he was aware that any further custodial sentence would mean his mother being committed to a care home. He conducts his transactions covertly via text messages, and despite being rich in recovery capital (not in financial terms, he is unemployed) remains careful when selling drugs, never selling them directly from his large sandstone home. Instead, he meets people at the gate at the bottom of his extensive garden on a secluded walkway. Wullie emphasises the "higher purity" of his heroin thus promoting the buyer's safety. I found that my data revealed the physical acquisition of heroin was devoid of anxiety one might anticipate given its illegal status (i.e., police intervention) or associated moral concerns. Observations detailed heroin transactions as "social" rather than "business" or "formal". For instance, observing Angela and James order and purchase heroin, they appeared unconcerned by the illegality of their actions or possible consequences, showing no fear or apprehension of the often-associated risks such as violence or theft often cited in drug related literature (see Bourgois, 1998; Parkin, 2013) or arrest.

Local police were aware James used heroin, as were other people in his village but he explained they did not approach him despite routinely walking to his heroin suppliers house to buy heroin and returning home to prepare and inject it alone:

> "Polis dinnae bother mi as long as am no daft…they ken whae a um an' whit a dae….but they leave us alaine tae git oan wi' ma life, but a dinnae take the piss" (James, aged 38).

Contrary to Saleme, et al.'s (2018) findings that acquiring heroin involves risk-taking behaviours associated with poor decision-making due to effects heroin has, my findings revealed participants, acknowledged the many harm indicators and risks but were cautious when it came to purchasing, using and selling heroin:

> "A don't sell tae anyone or buy from thum unless I know them" (Wullie, aged 42).

> "A yase one guy [to buy from], always take the bus so a kin ditch it or hide it inside [vagina]" (Ashleigh, aged 28).

> "Ma dealer leaves it in a secret place, so we never huv tae hand ower" (Harold, aged 44).

Harold acknowledged that violence and theft were synonymous with heroin use, but went on to elaborate that between those people who use and sell heroin within the region, both violence and theft were exceedingly rare because of the lack of anonymity, integration within their communities, friendship and drug using bonds:

> "Look, if you batter a guy an' take his gear and money, they urnae goin' tae go tae the fuckin' polis eftir aw. 'Scuse me officer, that man battered mi' and took ma class A aff me wi' oot peyin' fur it! [Laughs]. But….but, wait…. Right, ok, … if yi dae, if yer daft enough. You huv tae find a new dealer afore word gits around, and wurd gits aroond here faster than a greyhoond wi' its erse oan fire, because nae cunt will touch yi. 'Er no goin, tae take the chance, their no stupit …being an addict disnae mean yer dense, so you can only dae it yince, twice it maist and then….well…… the gig's fucked."

Harold's observations contradict Hoffer's (2016) ethnographic study of people who use heroin in urban Cleveland, U.S., which found violence to be prevalent among those people who use heroin and those who sell and distribute it. Instead, Harold's observations align with Parkin and Coomber (2009) suggestion that the media and researchers tend to focus on violence and chaos associated with "drug markets" neglecting any associated "mundane" aspects of the lives of those who use heroin. Violence of course has the potential to cause harm, isolating both perpetrators and victims, drawing attention from the police and wider society. Violence can result in physical injuries, mental trauma and death; the former may arguably serve as catalysts for victims to change their lifestyles and seek recovery. However, it can also function as a barrier to change if individuals feel intimidated or coerced into continued drug use or related activities or where perpetrators find breaking free of destructive patterns insurmountable due to their substance use disorder, potentially reinforcing them.

In Dumfries and Galloway, people who use heroin are well acquainted despite the extensive geography and relied on each other for heroin. Disputes, even violent ones (verbal or physical aggression, shouting or threats) were very quickly resolved to maintain equilibrium, facilitated by a small close-knit community of people who used heroin, a lack of anonymity,

and an interlinked heroin network that ran throughout the region. Friendship, loyalty, belonging and a desire to exclude the police also held significant roles in these interactions:

> "We fa' oot, [he and his brother] it happens, it's always happened and sometimes we roll aboot a bit [physical fight]… bit we're mates an' we've ey'wis been mates an' we always end up laughin' aboot it and that's wi' oot the gear!" [Laughs] (Neil, aged 37).

> "We 'ad a fight' like…proper ding-dong about nowt but we will be a'right, like….it 'appens from time t' time when we piss each other off like, but we're always alright though…he's me mate….am only one allowed t' touch 'im I won't let nobody else touch 'im like…been mates for years" (Mark, aged 30).

Violence is commonly linked to drug use between rival factions and people who use and sell drugs, arising from disputes over drugs, distribution, territorial and interpersonal conflict, as well as those suffering from withdrawal or under the influence of psychoactive substances. Consideration must also be given to intimate partner and interpersonal violence, which Zhong et al (2020) found to be comparatively less prominent than general violence. This may be founded on the fact that people who use heroin are less likely to have partners, be less likely to report violence because of their drug use or not be taken seriously by the police because they are "drug users". In the context of substance use disorders, the prevalence of violence increases 4-10 times than violence within the general population, also surpassing the rates recorded in severe mental health disorders. This highlights and strongly supports the need to address substance use disorders in any public health approach to prevent violence. As most people who use drugs in the U.S. where firearms are prevalent, do not receive or engage with recovery, this contributes to the elevated levels of violence within the drug-using population. This dynamic provides a distorted perspective of violence within the drug-using communities as a whole however and is often seized upon by the media. Arguably, recovery not only addresses issues directly related to drug use it also has a wider-reaching influence, such as reducing violence and consequently its impact on victims (Merline et al., 2008). Notably, the absence of observed incidence of violence identified in my data may be, among those factors already explored, influenced by my participants' ongoing engagement with SDAS recovery services and the consequent change this engenders.

Although heroin was readily available within the region, its acquisition within the most rural areas was more of a challenge compared with larger towns in Dumfries and Galloway, where a straightforward text message could lead to heroin being delivered. The acquisition of heroin, consistent with May and Hough's (2004) and Coomber's (2019) studies remained a *predominantly* face-to-face transaction. Buying heroin was akin to buying any other commodity, as demonstrated by Hoffer's (2016) exploration of "framing exchange," a perspective applicable to my participants. Here Gudeman's (2001) dialectic between market and community is embodied in the inter-subjectivities of traders, promoting both trust and at times conflict. In this context, conflict is the result of the perpetual ambiguity all market participants experience, but, unlike urbanity, rarely led to violence or long-term disputes, in fact, transactions were often social and good-humoured.

The procurement of heroin in rural areas posed unique challenges specific to rural living: a paucity of heroin sellers, a lack of anonymity, poor transport networks, unreliable phone and internet signals, extensive distances to travel to purchase and use heroin, and the ever-present local police, with their local knowledge. People who used heroin had to contend with and factor in common rural problems and issues including intermittent bus services, the impact of poor weather where snow commonly blocks roads in the winter and conversely, increased tourism and long journey times often stuck behind caravans and tractors in the summer. Navigating these challenges meant individuals had to carefully plan purchases and subsequent heroin use. Transactions were primarily organised around public transport, which either brought heroin to them or took them to their heroin suppliers, as I will explain.

I discovered that heroin use among my participants was carefully planned, controlled, and regulated. The reasons are underpinned in the narratives below:

> "Huv tae wait oan the bus fae the Rar [25 miles and at least 50 minutes away]…fuckin' takes ages whin yer rattlin' [withdrawing]. Or git the bus tae the Rar masel, but then a huv tae pey the ticket an' share ma gear if a want tae cook in a mates hoose there, or wait wi' it burnin' a hole in ma brain oan the bus till a git hame" (James, aged 38).

> "A git a bus tae CD [small town 35 minutes by bus from his hamlet] or cadge a lift….bit a huv tae wait 2 oors fur the bus back…so a git a cairry oot tae stoap the rattles an' sit

> in the park waitin' fur the bus, it's a fuckin' eternity [laughs], thin score when a git hame" (David, aged 32).
>
> "Git the auld dear [mother] tae drive us in (15 miles to the nearest town)….a huv tae make ma ane way hame [bus or walking] cos she will nae huv it (heroin) in her car" (Josh, aged 23).

Josh's mother, who did not use drugs, regularly drove her son to his heroin supplier, often providing money for his heroin purchases, although in no way condoning its use. She would not transport Josh home with heroin, fearing arrest by the police, but would drop him off outside his supplier's house. Josh's supplier would not permit anyone to prepare or use heroin in his house, Josh had the choice of taking a bus, which operated every 4 hours and took 2 hours via a protracted route to his hamlet, or his preferred option, a fifteen miles cross-country walk from his supplier to his home. Josh, the youngest person I met who used heroin, explained he used heroin every other day and prescription methadone daily. He bought and kept a quantity of heroin to last him several days. The nearest pharmacy was located one-hour away, approximately a 5-mile bus trip in the opposite direction to his heroin supplier, which again, he routinely covered on foot. Distance and travel time were often noted as having the potential to lead to lone heroin use as participants weighed up the risk of lone heroin use against travelling and waiting to use with a friend. Josh rejected opportunities for recovery and despite his mother's pleas, he moved to Newcastle to join an organised crime gang to further his drug career, I lost contact with him following his move.

The physical acquisition of heroin was a routine, straightforward transaction between the buyer and seller, like procuring any other everyday item. Both parties were careful not to draw unwanted attention to themselves from the police or from people who did not use drugs in their communities. They simply did not want interference in their everyday practices or heroin transactions. People who use heroin routinely used mobile phones and the social media platform Facebook to make enquiries and purchase heroin. Telecommunications and social media facilitated speedy communication regarding heroin availability while ensuring confidentiality and protection from the criminal justice system, by using simple encrypted messages, often without formal identification for instance:

> "Got n e? S." [Do you have any heroin for sale?], (Scott, aged 37).

> "Need 2.4" [need two 0.4.g wraps] with the accompanying telephone number sufficient to indicate the sender, (Wayne, aged 42).

Responses by text simply indicate whether the seller had heroin, "aye", and "on its way" with the physical transaction and payment completed in the individual's routine manner.

While the acquisition of heroin demonstrated social bonds and ties among those people who use drugs, individuals referred to people selling drugs, as "acquaintance" rather than "friend". When I was present, I found relationships to be cordial, with "banter" commonplace and reciprocal. My findings reflected warm and genuine greetings leading to extended interactions and conversations unless a person was "rattling". During these interactions, not only were relationships strengthened but misunderstandings and conflicts were often resolved through dialogue, reducing any ill-feeling or potential future conflict.

Close intimate bonds had both negative and positive effects on recovery. Shadur and Hussong's (2014, p.997) study of U.S. adolescents who use drugs "predict increased substance use" through sales and sharing drugs, a phenomenon not reflected in my study. Friendship, often considered recovery capital, was routinely cited negatively (negative recovery capital) when participants contemplated changing their drug related lifestyles, such as abstinence. While friendship provided companionship and a level of safety, protecting against overdose and the onset of withdrawal symptoms, it posed as an obstacle to reducing or ceasing drug use unless all parties (throughout the region) were invested in the same goal, an occurrence I never observed. People who used heroin demonstrated a customary ability to regulate and plan their heroin use. Chaotic and pressured use of heroin was not observed, a point to be discussed in Chapter 7. This ensured their capacity to plan and navigate considerable distances over extended periods to acquire heroin without drawing attention from the police or people who did not use heroin.

6.7 Administering heroin.

Within their everyday, people who use heroin in Dumfries and Galloway routinely needed a discreet environment for preparing and administering their heroin, often referred to "cooking" and "shooting-up". During my data collection, it was evident that participants generally preferred intravenous administration of heroin. Some people who reported chronic

heroin use noted that their veins had "collapsed" or become difficult to locate, leading to physical issues such as ulcers and scarring, meaning they would regularly burn and smoke heroin from foil, commonly known as "chasing the dragon". Participants in my study actively avoided and discouraged others from engaging in heroin use in public settings. This was primarily because, in line with the findings of Brown (2015), Farrugia (2016), and McElrath and McElroy (2001), people who did not use drugs from the community did not countenance public heroin use. Participants noted they would make negative comments if they witnessed individuals administering heroin in public spaces and often alerted the police to the incident.

Murphy and Waldorf (1991), Latkins, et al. (1995), Bourgois (1998), Carlson (2000), and Moraes (2001) note that people who use heroin in urban settings often administer the drug in designated environments colloquially referred to as "shooting galleries". Hoffer (2016, p.220) associates such "shooting galleries" to "male gender, low socio-economic status, and heavier drug involvement," characteristics commonly shared by my participants. Cellantano, et al. (1991), Latkins, et al. (1995), Bourgois (1998) and Hoffer (2016) describe urban "shooting galleries" serve as centres for people who use heroin to congregate, use, buy, rent or share heroin, and heroin paraphernalia, driven by mutual resource and economic need. The setting itself is believed to influence the drug's effect and general drug using experience (Zinberg, 1984: Stephens, 1991). Sherman, et al. (2004) noted that only 20% of people in urbanity who use heroin accessed "shooting galleries" with Schilling, et al.'s (1991) study of women who used heroin in New York reporting that only 2 women out of 91 frequented "shooting galleries".

Despite this, Sherman, et al. (2004) noted a high prevalence of public (outdoors) heroin use in urban areas, a behaviour neither practised nor tolerated by people who used heroin or those who did not in my study. My findings did not reveal the presence of "shooting galleries" or central congregational points where groups of people who used heroin "hung out" to "score" or "shoot-up" as identified below:

> "Shootin' gallery….eh? (Looks surprised, sitting forward in his chair). A 'hink yer watchin' too many American TV programs. Look, maist people jist stey in themsels or wi' a mate. Too far tae travel tae see folk an' yi dinnae want tae walk aboot gouchin' tae git hame in case the polis pick yi up or some eh they wee cunts try tae dae yi ower" (Deek, aged 48).

As the extract shows the suggestion of "shooting galleries" bemused, then amused Deek. Deek's response resonates with Parkin and Coomber's (2009) study, which investigated the experiences of 14 people who used intravenous drugs in south-west England. The study highlighted the notable absence of the term and use of "shooting galleries" by their participants. Parkin and Coomber deemed the term to be outdated and emotive characterising the use of the term "shooting galleries" as conceptually "fictional places" that serve to stereotype people who use drugs. Parkin and Coomber advocate the term "communal indoor injecting environments" as a more acceptable and accurate nomenclature. There term reflects shared spaces where individuals use drugs and importantly departs from outdated and potentially damaging connotations often associated with the term "shooting galleries".

Deek explained that the closest he came to a "shooting gallery" experience, was when he and one or two "pals" occasionally hired a caravan overnight at one of the many caravan parks located throughout the region during the Glasgow Fair or "Trades" (a 2-week holiday period for manual labourers) in July. Caravan parks offer safe and affordable family accommodation close to the Solway coast and are a popular destination for vacationing city-dwellers such as Glaswegians. With the arrival of vacationing families, Deek explained the temporary population exodus led to a reduction in heroin customers and sales in Glasgow. Consequently, individuals involved in selling drugs simultaneously vacationed and sold heroin and other drugs. In this context, Deek and one or two "pals" converged to network, purchase, and sell various drugs. However, the primary motive appeared to be to enjoy a night or two of partying and getting high on heroin, benzodiazepines, and alcohol. His only other communal indoor injecting environment was limited to a friend's house, or when his friend visited him, ensuring a safe, secure, private and familiar setting. Choosing these environments ensured Deek and his friend mitigated unwanted attention, social stigma or criminal justice involvement, all of which are affiliated with the term "shooting gallery," it also reduced potential overdose.

Perhaps as a result public use and administration of heroin was not problematic within Dumfries and Galloway:

> "Naw naebody shoots up in the toon, they nivur huv no since a huv been takin' gear anywey and that's (pauses to calculate)…..fuck, 40 odd year (pauses to contemplate the time). Why wid yi want tae fix in the street? Fuckin' nae need, gits peoples backs

> up…..'errs plenty o' hooses available, there's nae need fur anybody tae be oan the street or fixing' on the street there nivur hus been…it yased tae be thit there wis only a few ae us oan the heroin anywey, no thits there many mare noo right enough. We stayed in or went roond tae ither users, bit maistly just yased oor ane hoose" (Jimmy, aged 66).

In more rural areas, a few participants reported allowing a "travelling customer" to use their home for intravenous heroin administration, but this was very much the exception [rather than the rule]. There were several reasons for this but primarily it was not to draw the attention of people who did not use drugs, not only through fear of police involvement, but importantly, to prevent negative perceptions within their community. One low-level person who sells drugs explains:

> "Yin guy OD'ed, [in her home] fuckin' nightmare a hud tae kick him oot and he was shoutin' "robbin' bastard" back at mi, fuckin' redder [embarrassment] in front ae the neighbours. So now a jist gie thum thur gear and tell thum tae gaun" (Rebecca, aged 28).

Rebecca resides on the top floor of a low-rise block, consisting of six flats, three at either side of a communal stairway in a small town of under ten thousand people. Her family are unaware she uses drugs, although her partner was trying to consolidate his position as a level 2 person who sold drugs in the town. On one occasion, she allowed a male customer, from another town and suffering withdrawal symptoms, to administer heroin in her flat.

Unfortunately, he overdosed following a "bad hit" (two "hits" in quick succession, where the first is deemed ineffective). Having received training from the SDAS, Rebecca administered naloxone to save his life. Upon regaining consciousness, and in the throes of acute detoxification, he became aggressive and demanded free heroin from her, but Rebecca refused. Her large bulldog cross dog intervened, worrying the leg, arm and hand of the man. To appease him Rebecca gave him free heroin and a towel for his wounds before making him leave. She chose not to contact emergency services to avoid potential arrest or attract undue attention from her neighbours. She admitted feeling vulnerable and angry at placing herself at risk and no longer allows people to use her flat to "cook" or "shoot-up".

John, a needle exchange worker from SDAS, shared that "users" typically stay within the confines and privacy of their homes. While some generally use heroin with a partner or friend, some worryingly opt to use alone. He emphasises the risk of overdose was higher when using heroin in solitude. A positive consequence, he reports, is that rural people who use drugs in solitude are:

> "a wee bit mare canny when usin' jist in case thay dae gaun ower [overdose] when thur by thumsels…..bit ers no shootin' galleries doon here like in Glesga' (scoffs), there's no that many thit yase heroin anyway….even aw the gither a dinnae 'hink they wid make a perty nivir mind a gallery".

However, tragic outcomes did still occur even when people who used heroin administered drugs together. This was highlighted during a conversation with a small-town individual who sold drugs who permitted a local individual engaged with drug use to "shoot up" in her flat:

> "It's bettur if they ur here a kin keep an eye oan thum (proxy consumption room)…I huv naloxone in case, but a young boy OD'ed, Weasel [her partner] foond him in the moarnin 'ere, (she points to a box room) a phoned fur the ambulance bit a kent he wis deid. His faimily blame us. They tried tae hammer [assault] us, they dinnae leave us alaine now so a dinnae lit any yin in noo, jist deal through the lettur boax. The polis wur everywhere… (hesitates), we stashed oor gear afore they turned us oor though, bit we hud tae gie statements n' stuff. They wur gonnae charge Weasel wi manslaughter bit he gote oaf cos they could nae prove we gave um the gear which we didnae! He wis already gouchin' whin he gote here we jist gave him a bed. Anywey…we cannae git an exchinge [move accommodation] cause a cannae tell thum [housing authorities] the right reason fur tae move us" (Carol, aged 40).

Carol went on to express her apprehension about the consequences of using when Weasel, her long-term partner is working. Although being tempted, she restricts her heroin use to occasions when they use heroin together to mitigate the risk of "cowping" [overdose]. Carol had allowed people into her flat to "cook and shoot-up" in the past, for communal drug preparation and use so they could "look oot fur each ither", but she has since adopted a more cautious approach to regulate her heroin use and is risk aversive despite having heroin available.

In summary, people who used heroin in my study predominantly used their homes to prepare and administer heroin, primarily because they have homes. There homes reflected private, comfortable environments, which were safe from other people, the inclement Scottish weather and police. The absence of communal indoor injecting environments and outdoor heroin administration sometimes noted in urban settings highlights a distinct behavioural pattern amongst rural people who use drugs and who consistently demonstrated they did not identify with these activities. My findings revealed naloxone and its use to be common amongst my participants, a practice facilitated through training and provision by SDAS staff, but one which is restricted to their clientele, participants also used their friendship bonds to share sterile equipment and communicate drug related information. My findings align with Parkin and Coomber (2009, p989) previous assertion that highlighted "the willingness and support of IDU to become involved in such drug-focused activism". Exemplifying a proactive stance amongst people who use drugs to safeguard themselves and others who used drugs (friends and acquaintances) from potential risk associated with drug use, whilst simultaneously challenging the notion that people who use drugs lack a sense of agency, compassion or responsibility.

Participants consistently proved a propensity for self-regulation and controlled drug use. They concurrently engaged with practices associated with both recovery capital and harm reduction. These behaviours, extended to shared, regulated drug use, substitute prescribing, sterile equipment use and the use of sharps boxes for used needles. The influence of both recovery capital and from what Cloud and Grandfield (2008) identified as "negative recovery capital" notably manifested in the region's heroin-related deaths. Toxicology reports consistently revealed the presence of prescription methadone, mainly in conjunction with alcohol and street benzodiazepines in cases of heroin-related deaths. This pattern of deaths was often associated with men and isolated heroin use, where the presence of naloxone was evident but unused arguably, highlighting a disconcerting dimension of "negative recovery capital" within the rural setting. Polydrug use was noted as a change in the everyday practices of people who reported long term use of heroin and coincided with the increase in the regions drug-related deaths to an otherwise stable drug-using community.

"Negative recovery capital" extended to friendship bonds, while identified as essential for accessing heroin and promoting safe drug use, simultaneously functioned as a barrier to individual change. Strong and enduring friendships routinely located within the network of people who used heroin facilitated shared drug use, reduced the risk of drug-related deaths, and

provided essential support and well-being. Lone drug use heightened the risk of overdose and drug-related deaths, a recognised risk among my participant group. Where friends could not contact each other due to rural challenges such as poor transport networks, mobile phone signal issues and distance, individuals would resort to solo use with its associated risks. Further to this, individual recovery pathways proved challenging where friendship bonds had formed, unless these groups collectively sought to change. This was fundamentally due to a lack of anonymity, a desire to remain within the area, and the enduring nature of existing friendships and the security they brought. Developing a new recovery-based identity and friendships independent of heroin using associates and heroin was challenging whilst remaining within the same community making individual-based recovery feel inaccessible to many.

6.8 The product: Rural heroin.

I spent a day with Nikki in her small, dark, ground-floor flat. Nikki operated as a level 2 individual who used and sold drugs situated in a small town of fewer than ten thousand people. She had used heroin for over 15 years resulting in, periods of imprisonment and both of her children being removed from her care, she was single, and I was concerned at her vulnerable situation. Nikki sold .4g of heroin in small cellophane wraps for £20 each. Her clientele contacted her on one of the five mobile phones neatly arranged in front of her, confirming their needs, before turning up at her flat. She lay on her sofa in her living room, covered with a blanket against the chill of spring. When people knocked on her door, she shouted "come in" – as there was no lock on the door. Nikki, echoing Harold's sentiments, stated that no one would attempt to rob her as anyone who did would "nevir git fuck all again". As we sat chatting, unthinkingly, I asked her how good her product was. Nikki nonchalantly shrugged; she had no idea. She then quipped, "Gid enough tae sell" [laughs]. With almost comedic timing, a knock on her door alerted us to the fifth customer of the morning. It was 0930 am. A small thin man in his thirties with shoulder-length blond hair, dressed in a dark Adidas tracksuit and trainers entered; he was well-kempt and looked physically well. He, as with the previous customers, stopped and eyed me suspiciously, but Nikki resolved his concerns with a simple "he's wi' me". Later, I learned Nikki had told them I was "security", resulting in several outstanding debts owed to her being promptly settled. The transaction was brief, and they exchanged pleasantries before he nodded goodbye and left without making eye contact with me. My presence had evidently hurried the transaction as Nikki stated he usually stayed to talk. Many of Nikki's customers were not known to SDAS, she explained that they did not need or want to interact with them.

Nikki's perception was that heroin purity within Dumfries and Galloway was notably low and the product poor. She acknowledged that she had no way of testing its purity beyond comparing it with heroin she had used outside the region. It was, as she correctly claimed, good enough to sell and when I left her at 1pm so she could sleep I had counted 14 customers. She was not alone in identifying issues with its low purity and poor quality, however. My own data supported her assumptions, as heroin quality was routinely noted as poor by people who used it throughout the region. The widespread sentiment about its inferior quality undermined its potency and effectiveness, as highlighted below, ultimately questioning its appeal:

> "Couldn't believe 'ow crap it were up 'ere, in York its miles betta" twice or three times as good ….it's 'ardly worth the trouble of takin' it, a 'ave t" use benzos and go t' fuckin' Cameron 'ouse for meth to make sure a git through day" (Dan, aged 38).

> "It's shite, hardly worth the fuckin' bother" (Deek, aged 48).

> "Shit. Now anyways…its aw cut an' cut again until 'er's fuck awe bit shite, yased tae be bettur ten tae twinty year ago but noo...pah!" (Jim aged 67).

> "Quality is mostly rubbish, sometimes you get an odd, good batch from Glasgow but that usually happens when people up there stop buying and use benzo's or even coke (cocaine) - we get the overflow" (Bonnie, aged 36).

> "Fuckin' shite…. its 90% benzocaine and 10% shite [laughs]" (Josh, aged 23).

> "…it comes up frae Liverpool maistly cos that's the best stuff, a git a tenner or a twinty (.1 or .4g wrap) but its fill wi benzocaine…a 'hink that's what did ma leg [shows me a large scar where an ulcer has now healed] it's shite quality to be honest" (Mike, aged 32).

Participants from more rural areas consistently reported heroin quality to be better in Dumfries town compared with their own locales. They speculated that as heroin made its way from the larger towns to more rural areas its purity reduced, as they assumed it was adulterated with additives en route to them. This perceived decline in purity and quality resulted in increased

purchases and use. There was, however, no evidence to support their assumption. Many participants from Dumfries expressed the belief that heroin quality was poor regardless to where it was purchased in the region. Traditional £10 .1g wraps were making way for £20 .4g wraps with participants reporting they used more heroin per "hit" to attain the required affects, suggesting an increase in heroin consumption, despite a noted fall in people using it. This phenomenon may also be a contributing factor to the regions increased overdoses and drug related deaths among an otherwise stable group of people who used heroin. According to Dumfries and Galloway Police (2018) heroin purity consistently remained low at 10% throughout the region. In contrast, the U.K. Focal Point on Drugs (2017) reported a mean heroin purity of 43% in England and Wales, aligning with Dan's experience in York. The reasons for low purity heroin within the region were unclear. People who sold drugs at all levels refuted any notion of cutting or adulteration of their product, and it was not an action I observed.

Illicit heroin lacks any quality control measures, leaving people who use it to gauge its purity following its use. Lahaie, et al. (2015, p.598) highlighted in their study based on heroin use in France that "poor quality street samples coexisted with infrequent occurrences of high-dosed retail quantity of heroin". Thus, the potential for variability of heroin purity within the region poses a significant risk of overdose, especially in the context of "poly-substance use" where alcohol is also imbibed, and lone administration takes place. A subpar heroin "hit" (referred to as a "bad hit") which fails to deliver the expected "high" in the anticipated timeframe was often promptly followed with another "hit" to compensate. The combination of two heroin intravenous administrations in quick succession was routinely cited within my findings as a prime reason for overdose. Participants understood this risk, yet many reported the behaviour at some point of their drug taking history. For example, Deek, (aged 48) recounted "when a wis younger, a woke up in A+E (because of) a dirty hit" but attributed "dirty hits" to inexperienced heroin use during his youth. The potential is a delayed onset of the effect from the first administration, coupled with the simultaneous impact of the second administration, leading to overdose and unconsciousness. Despite the inherent dangers, the risk of overdose and drug related death did not stop or deter the use of heroin among my participants. Such incidents only served as timely reminders of mortality, prompting some individuals to temporarily moderate their drug use following any reported overdose or death among their community. My participants also noted that heroin wraps purchased at the same time, even from the same individual varied in purity. The inconsistency in heroin purity was, however,

enhanced by methadone (24-hour half-life), large quantities of inexpensive street benzodiazepines (of unknown purity) and alcohol consumption.

One positive yet unexpected consequence of low-purity heroin within the region was that people who used it routinely attended recovery services for methadone. My findings consistently identified that the poor quality of heroin, free methadone, and the potential of unreliable heroin supplies were primary reasons for accessing the SDAS and the free recovery capital they provided, not abstinence. These findings contradicted previous claims made by participants regarding the perceived stability of heroin provision throughout the region, the lack of benefit from methadone, and the inconvenience of obtaining it.

> "Yi dinnae understan'…right lit me explain… a junkie's worst fears ur the rattles and then no being able tae score….right? Aye, er's always gear oan the go bit…an' the gears always shite nae metter where yi go, a ken cos a hud proper stuff in the Dam (Amsterdam) no like these bumpkins. They widnae ken gid heroin if a smacked thum on the back o' heid wi' it [laughs] nae pun intended. Anywey, whit happens if it runs oot? A ken it's no, you ken it's no and a ken it willnae but an addicts heid willnae take that chance [laughs] so yi jump through the hoops it Cameron Hoose tae git yer meth and tell thum whit they want tae hear tae keep that script goin' jist… in…. case…. the gear ***does*** run oot. In the meantime, yi become as addicted if no mare sae tae the meth! Cannae fuckin' win [laughs]" (Billy, aged 59).

SDAS confirmed that they used the opportunity of prescribing methadone to assess, monitor and evaluate people who use heroin within the region while maintaining regular contact with them. They issued "daily scripts" that necessitated fortnightly contact to maintain them. Daily scripts meant people who used drugs were required to visit their local pharmacy for observed methadone administration. Periods of lost contact, typically 48-72 hours, were reported to the SDAS by the pharmacy. SDAS then contacted the individual to assess their well-being. If three consecutive days of lost contact occurred with the pharmacy the individual was required to attend SDAS in person for an appointment and mandatory drug screen, thus promoting stability in their drug practices. These points may also highlight potential reasons why not all people who used heroin engaged with the recovery resources provided by SDAS. My finding suggests that approximately half of the people who engage with drug use attend and are registered with

the SDAS. A considerable proportion of people who use heroin did not use recovery resources in the region, potentially increasing their risk of overdose and drug related harm.

Darke (2016) found only a moderate correlation between heroin purity and overdose, as people who use drugs titrate their heroin intake based on local purity and their individual needs, a phenomenon also evident in Dumfries and Galloway. My findings also revealed that participants routinely supplemented their heroin and methadone with street benzodiazepines, alcohol, and other recreational drugs such as cannabis and occasionally cocaine. They also consciously exaggerated withdrawal symptoms and underplayed the number of illicit drugs they consumed to have their methadone increased or to receive prescription benzodiazepines. Poly-substance toxicity, as a result, was positively intimated in all the region's drug-related deaths (Scottish Government, 2020). The fluctuating purity of heroin, combined with the routine use of other illicit drugs of uncertain purity, alcohol and the daily administration of methadone, particularly when taken in isolation, made drug use hazardous. Whether heroin purity plays a negative or positive role in recovery remains open to conjecture. In a field memo I wrote: "heroin purity is consistently decried as poor, so why do people continue to use it? Is its use symbolic? Perhaps this is why younger people are not using heroin".

In summary, participants explained that heroin is readily available and easy to obtain within the region. Its purity despite being unknown is consistently denigrated by both those who purchase it and by those who sell it. To compensate for its perceived inferior quality, participants reported using more but my findings indicate a decline in heroin use within the region. There is a notable trend, explored more extensively later, involving increased poly-substance use, including illicit benzodiazepines, prescription methadone, and alcohol among participants. This trend may contribute to the rise in drug-related deaths, especially amongst men who appeared to engage in poly-substance use more readily than women. Several participants were asked why they continued to use low-quality heroin, raising questions pertaining to whether the perceived benefits of it use outweighs the financial costs or if it is habitual behaviour.

6.9 Income generation.

Income generation constitutes an integral element of the everyday practices of people who use heroin, irrespective of their environment (South, 1999). Previous research has demonstrated that the generation of funds to purchase heroin is a priority for those people who

use it. Income generation may lead to selling their property, selling drugs, and engaging in both non-violent (begging, theft, and prostitution) and violent (mugging, armed robbery, and homicide) activities (Draus et al. 2010; Maher et al. 2002; Mott, 1992; Strang and Gossop, 2005; Sutton, 1995).With the exception of regular employment, the income-generating behavioural patterns of people who use heroin typically map to the "heroin using stereotypes" for income generation (Draus, et al. 2015; Draus, et al. 2010; Maher, 2002; Sutton, 1995). In urban settings, opportunities for income generation abound, ranging from conventional employment and gig economy jobs to alternative avenues such as selling the "*Big Issue,"* engaging in zero-hours contracts, and cash-in-hand employment (mostly in the low-income labour market). Additionally, people who use heroin in urban settings may turn to begging, selling drugs, theft, prostitution, shoplifting and burglary (Maher et al. 2002; Moyle and Coomber, 2015). Conversely, people who use heroin in rural settings face quite different economic challenges, (Winters, et al. 2009), including lower populations, limited industrialisation, a slow economy and lack of anonymity (Tuan, 1976; Zografos, 2007; Steiner and Teasdale, 2019). Despite these differences, people who use heroin in rural settings still need to generate funds.

As outlined by my study participants, heroin is priced at £10 per.01g or £20 0.4g in Dumfries and Galloway. The average daily use is approximately 0.2g, equating to approximately £600 per month for £10 wraps (£7,200 annually) or £300 per month for .4g wraps (£3,600 annually). A notable paradox exists wherein wealthier people who used heroin who could afford more expensive wraps accessed less expensive and potentially more heroin. When extrapolated to an estimated 1,500 people who used heroin in the region, this expenditure equates to between £5.4 and £10.8 million annually.

Scholars, such as Dorn and South (1987) and Morton (2019), however, commonly associate heroin use with social deprivation and impoverishment. Indeed, most participants in my study resided in deprived areas notably in "schemes"- low-cost rented houses provided by the local authority, predominantly situated in impoverished areas. All participants relied on various unemployment (state) benefits as their main source of income. Participants in my study were not actively seeking legitimate employment, the opposite was true, and they actively sought to remain unemployed. Their preference to remain unemployed stemmed from the perceived greater income from state benefits, which were dependable and paid fortnightly directly into their bank accounts compared to potential earnings from employment in the region. When

applying for and being assessed for benefits they routinely emphasised and exaggerated the impact drugs were having on their lives to ensure they continued to receive them. For instance, Lee and other participants discuss Employment Support Allowance, (ESA), a state benefit amounting to £308 per month paid to people with a disability or health condition (mental or physical) such as "addiction" to heroin that impacts a person's ability to work.

> "A dinnae really want tae work…cannae really be arsed and ESA pays well", (Lee, aged 42).

> "Cannae afford tae fuckin' work….yi jist tell thum [benefits assessors] what they need tae hear, yi know yer depressed n' anxious and if that isnae workin' jist tell thum yer suicidal and ur thinkin' aboot toppin' yersel, every cunt does it" (Deek, aged 48).

> "Workin' oan the books isnae worth it, a cannae make ends meet, so a stay oan ESA and work oan the side" (Brian, aged 29).

> "A would like tae work a mean pay tax an' stuff….but it's no worth it, with ma ESA an' working oan the side a jist about manage" (Ashleigh, aged 28).

According to the Scottish Government (2020) statistics, average earnings within the region amount to £480 per week gross, around £25,000 per annum, representing one of the lowest levels of income in Scotland. In rural Scotland, approximately 50% of all employment is full-time and the other 50% is split between part-time (31%) and self-employment (22%). However, unemployment rates are lower within rural settings when compared to urban areas in Scotland, due to economic migration of working-aged individuals to urban centres, leaving a higher proportion of older people (pensionable age) in rural settings. Notably, the public sector is the predominant employer in rural Scotland (encompassing roles in local authorities, NHS and emergency services). Following closely behind are the hospitality and service industry, with agriculture contributing only 6% to the region's employment, which was an unexpected finding considering the rural context.

As outlined above, government benefits constituted the primary source of legitimate income within my study, specifically Employment Support Allowance (ESA), a benefit provided to those unable to work through ill health (such as "addiction") amounting to £308 per month.

Significantly, this benefit serves as a gateway to other monthly benefits, including housing support (rent payment) of £320, Council Tax exemption of £100 and Personal Independence Payment (PIP) (aimed at assisting individuals with ill health, amounting to £355- equating to £1255 per month approximately £15,000 per annum. Housing support and Council tax payments go directly to the property owner and local council. ESA and PIP go directly to the recipient (7,000 total recipients in Dumfries and Galloway in 2018). For the estimated 1,500 people who use heroin within Dumfries and Galloway, cash benefits equate to between £9 and £10.8 million per annum, contributing significantly to illicit heroin expenditure in the region.

Note: Additional potential benefits include free medication, healthcare, (subsidised) bus/train travel, food vouchers, electricity and gas vouchers, and (basic) furnishings with free accommodation.

Findings from my study align with Draus, et al.'s (2010, p.842) assertion: "Righteous dope fiends were proudly defiant of conventional expectations of work and routine." Receiving ESA not only provided financial support and a gateway to further benefits but also relieved individuals of their "unemployed" identity. This distinction was significant because it negated the perceived social and cultural stigma associated with unemployment, a stigma which surprisingly weighed heavily on the study participants and was vehemently rejected:

> "Am no fuckin' on the dole (unemployed) am oan the sick (stated proudly), am no' a workshy doley a wid work if a could but am no fuckin' well, so a canny" (Deek, aged 48).

> "A git peyed fortnightly"
> "You're working?" (Researcher)
> "Naw, nut a git ESA, am no' fit for tae work, a wid if a could though" (Paul, aged 42).

Paul, as with other participants, referred to his benefits payment as a "salary", a term commonly used and consistent with Bamberg's (2015, p.181) study, which cites "respondents in high-claim areas were *more* likely to stigmatise benefits." Like others, Paul, distanced himself from social stereotypes and stigma associated with being unemployed and receiving unemployment benefits by identifying as "sick" and renaming benefits as a "salary" aligning with terminology

used for employed individuals. It also maintains a level of impoverishment which becomes long-term and cyclical in nature.

Although Brian and Rhonda reside in the same house, they do not identify as co-habiting when claiming benefits:

> "We ur baith oan ESA, so we canny work, no thit we dinnae want tae you understand….. bit we pit doon we're no' the gither cos yi get mare coin that wey" (Rhonda, aged 29 with her co-habiting partner Brian, aged 29).

They indicate on their benefits applications forms they share a home, resulting in individual benefits payments. This practice, customary among their peer group and supported by my data, involves people in a relationship not disclosing their status when applying for benefits. This ensures they received the maximum financial award, which is higher for individual claimants rather than for couples. This practice is considered fraudulent by government agencies and can result in benefits being withheld and prosecution but did not dissuade my participants. They expressed a clear reluctance to work, but they also did not want to be perceived as unemployed or lazy by their communities. Consequently, they asserted a willingness to work if they could, although several were employed but did not declare it as their benefits would stop. This emphasises their inability to work through ill health, unintentionally aligning with the medical model of addiction by self-identifying as being "oan the sick." This alignment of being an "addict" enabled access to recovery capital in the form of monetary benefits, housing and tax relief, a position that was routinely embellished to ensure ongoing benefits and methadone.

In addition to the income strategy involving government benefits, my findings suggest three other concurrent income generation strategies. Consistent with Biernacki's (1979) study of 1,600 prisoners in California, the primary means of generating income for people who used heroin in my study were selling drug ("dealing"), theft and the gig economy, which I detail below.

6.9.1 Selling drugs.

As I have previously highlighted, my participants engaged in both using and selling heroin, the majority functioning as small-time sellers with small amounts of sales. Income generation from selling drugs typically yielded low financial returns. In the case of level three

sellers, profits were often negated, as they would normally repurchase heroin from their buyers (often days later) at the same price they initially sold it. Level three sellers would purchase several wraps of heroin from level two sellers, and subsequently sell them to friends or acquaintances, usually without a cash profit. Transactions frequently involved the exchange of street benzodiazepines, ranging from two to ten tablets provided by the buyer as part payment or as a gesture of goodwill. These benzodiazepines were then shared for immediate consumption or traded later in subsequent deals with the same individuals, without involving a cash exchange.

Such exchanges observed within this drug-related context reflect Marcel Mauss's (1950) conceptualisation of "gift exchange." Mauss contends gift exchange transcends simple economic transactions and is a fundamental social phenomenon involving social, moral and religious dimensions as they create and cement social bonds. Mauss posits his concept of "gift" holds a pivotal influence on the cohesion of traditional societies, embodying three fundamental obligations: to give, to receive and to reciprocate. Applying Mauss's theoretical framework to my participants draws parallels with his perspective of "gift exchange" where the act of giving also creates a sense of obligation. Participants bestowed "gifts" such as benzodiazepines, alcohol or cigarettes under a banner of kin or friendship. "Gifts," as part of an unspoken accord, arguably provided a sense of security for people who used drugs. By bestowing a "gift" of drugs, they felt justified in approaching the recipient to seek reciprocation later. Those people who received "gifts" were also aware of their part in the obligation for reciprocation later. In many ways participant's pooled and shared their drug related resources under an unspoken accord, resources which were "gifted" and reciprocated when individual circumstances permitted. This dynamic reflects an intricate relationship of my participants' social obligations to each other within the context of drug-related "gift exchanges" and associated "obligations" thereafter. This, of course, cultivates interdependencies and fosters social connections, further strengthening bonds formed in drug use, which may prove challenging to leave or overcome, arguably serving as an obstacle to change. There were notable exceptions to this where drugs were given without expectation of a reciprocation.

John, (40) for example, smoked a daily £10 wrap of heroin with friends. He used money given to him by his "ex-girlfriend" (being separated meant they both received additional benefits) and the mother of his three children to purchase two weeks' worth of heroin at a time benefitting from a "bulk purchase" transaction where £150 equated to 20 £10 wraps instead of

15. Although John received benefits, and expressed no desire to gain employment, he routinely passed these to his "ex-girlfriend" who did not use drugs whom he shares a house. In return, she provides him with a fortnightly financial allowance ensuring she has control and access to his benefits which bolster her monthly salary from her job in retail, allowing her to take care of their children and household needs. John either sold or gave his extra wraps to his friends or traded them for street benzodiazepines which he then shared with his friends for free, and he rejected any notion of recovery in any context. He was vague when explaining what happened to any potential profit:

> "Yeah, a get a couple of weeks' worth at a time, it's cheaper. I use a wrap a day…just smokin' now, after a drop the youngest at primary (school) an' I sell the rest to my mates if they have coin or swap them for Xanax. Look, you cannae sit and get high in front of your mates and no share and they have looked after me manys-a-time [when he had no heroin], so it's all good. Then a pick the young yin up at half-three from school, get home, tidied up and get the tea on."

For people at level two who used and sold drugs, my findings indicate that income generated from selling heroin is used to purchase more for resale. Additionally, it is used to offset the costs of their personal drug use and their daily living expenses. These expenses often extended to caring for family members:

> "A dae a bit o' dealing, nowt big but enough tae keep aes right and earn a few boab an' make share the family huv gote the 'hings a nevir hud (clothes, holidays)" (Mark, aged 38).

As with Neale, et al.'s (2012) findings, people who used heroin in my study routinely fulfilled their financial responsibilities, including utility bills and supporting family members. Mark, for instance, ensured financial support for his "ex-partner" and two children, using ESA, related benefits and recovery capital from SDAS. Mark, lives in the family home with his "ex-partner" and children but also had his own local authority flat which he uses as an "address" to claim benefits but sub-lets that to a friend for cash. Combining his benefits with income from selling drugs, Mark's monthly gross income ranges from approximately £2,000 - £3,000. Employment would significantly decrease his income, arguably making him impoverished. Mark rejects such a proposition by routinely emphasising his "addict identity" when being assessed by state

agencies. Similarly, Ashleigh and Wullie used income generated from the sale of heroin and their benefits to cover their heroin-related expenses, daily needs and, provide care to their relatives. Ashleigh was the sole care-provider for her chronically ill grandmother and Wullie for his elderly, chronically ill, mother. Both identified that their caring roles meant that working would be impossible, but neither felt the need to cease their drug use in their situations. Level three people who use and sell drugs, such as Billy, generated a substantial income from heroin sales. Billy sold heroin for a criminal organisation outside the region, receiving heroin, street benzodiazepines and "beer money" as payment, alleviating financial responsibilities from his wife and children, who managed Billy's benefits alongside her salary as a healthcare manager.

6.9.2 Theft

In my study, only one individual disclosed that they routinely stole to fund their heroin use, supplement their benefits, and maintain financial stability for their partner and children. The individual reported shoplifting to order often under the influence of heroin or methadone. Their preference was to travel outside the region to Manchester, where a greater range of shops were available. They charged 50% of the marked ticket price for the stolen goods, including such items as food, beverages, clothing, jewellery, white goods and televisions using borrowed vehicles to transport heavier items:

> "I can get you anything you want….no problems just give me a list; it will cost half the ticket price in cash".
> "How do you steal washing machines?" [Researcher].
> "Confidence! Walk in, find the dopiest assistant, and get them to help you carry it out to the van. I have only been caught once, stealing cheese from Tesco, I wasn't well [withdrawing] in the end they felt so sorry for me they let me go and they let me keep the cheese! I am an expert at what I do, I mean I am really fucking good." (Lee, aged 42).

Four participants acknowledged resorting to theft in the past to fund their heroin use, despite having recovery capital in the form of financial benefits and prescription methadone from the SDAS. Two individuals participated in burglaries, while one stole a doctor's prescription pad to obtain prescription benzodiazepines they later exchanged for heroin. Another participant engaged in shoplifting, using her pregnancy and children to cover her thefts. All four reported getting caught and incarcerated because of their actions. The two involved in burglaries

described themselves as prolific housebreakers, although they operated independently of one another. They stopped stealing following their liberation from prison, attributing their decisions to extended periods from loved ones and being briefly ostracised by their communities. This did not extend to drug use. The financial gains from their illicit activities were primarily directed toward purchasing heroin, with the woman also using proceeds from her illicit activities to address the needs of her children, who had latterly been taken into care by the local authorities:

> "Shoplifting with the kids was easier than when I was myself, and I mean who is going to search a pregnant lady? I used to cram so much stuff into my son's winter all-in-one that he could hardly move [laughs]." (Angela, aged 45).

Angela had her children removed from her care by the authorities after being caught stealing. As a direct consequence of being prosecuted, she received a drug treatment and testing order which included a prescription for methadone, allowing her to maintain contact with her children who were then raised by Angela's parents. All were vociferous in stating that they no longer committed theft, explaining the reason for their decision was due to family commitments. They all reported stopping that activity but not their drug use. They now relied on government benefits and low-level "dealing" to cover expenses related to their heroin use and other daily needs. Angela's partner, who did not use drugs, worked and provided financial support to assist her in purchasing heroin, which also helped regulate her heroin use and maintain her safety. My findings also revealed that most participants within my study not only distanced themselves from theft, but they also actively disapproved of those who resorted to theft to finance their heroin use, collectively labelling them "giro junkies". A member of SDAS referred to "giro junkies" as, "I.V. users who stay on the peripheries of society …they steal from their grannies and then try to justify it". Despite attempts, I could not source a "giro junkie" to participate in my study.

6.9.3 Gig economy: Cash-in-hand (casual) labour

A hidden economy of cash-in-hand off-the-books employment was prominent throughout my findings. Several participants had been or were currently engaged in unofficial and informal employment encompassing manual labour (roofing and labouring), agricultural work ("beating" (flushing) game birds for shoots) and the hospitality sector (server and kitchen porter). Hourly wages were generally lower than that of legitimate workers and employment

was sporadic, mostly on an "as required" basis. However, these points were not problematised; they were accepted as part of the arrangement:

> "A work fur a roofur when they need us, it's great a git to go awe ower the country, a git £40 a day (£5 per hour) in 'and" (Wayne, aged 42).

> "Brian works up the estate (home to a wealthy landowner), he gets £25 a day (£3 per hour) and his dinner…..that's fur either beating [flushing game birds for shoots] or rearing [tending game birds]" (Rhonda, aged 29).

> "Am a waitress….cash-in-hand like….but am gid at it…the customers like us so a git £7.50 an oor, plus tips an' as much as a want tae eat, no that a eat much. A can make aboot £50 a shift an' about £30 in tips. No bad eh? A work fur it likes, bit their always oan the phone tae me tae work so a must be dain' sumhin' right" (Ashleigh, aged 28).

My research reveals heroin was readily available and easily sourced throughout the region. Income generation, however, was limited to benefit payments, low-level sales and cash-in-hand employment often involving physical labour. Arguably emphasising the need for regulated and controlled heroin use. Income generation through criminal activities was very much the exception in rural Dumfries and Galloway, which contrasts with urban settings. Furthermore, such forms of criminality were viewed negatively by members of the rural community engaged in heroin use, who actively discouraged others from such activities. Participants in my study took their financial responsibilities and obligations seriously, prioritising everyday costs such as food and utility bills. Additionally, addressing drug-related debts and fulfilling family obligations and responsibilities were common financial priorities in my data.

In this context, I discovered an anomaly: although heroin, albeit of poor purity, was widely available, people who used heroin consciously restricted and controlled their consumption, despite having consistent funds to buy it. Participants adhered to their budgetary limits, occasionally borrowing money or heroin when needed but timeously resolving debts as agreed. Those who did resort to theft found a willing market exclusively amongst the people who did not use drugs in their community. However, common income-generating activities associated with people who use heroin in urban settings such as theft, muggings and prostitution were not

recorded within my data. “Negative recovery capital” was a dominant and significant feature of income generation. Without government benefits, the landscape of income generation would arguably be very different. Nonetheless, people who used heroin in my study were steadfast in their avoidance of the label “giro junkies” as they were of “recovery”. By eschewing stereotypical income-generating activities, they maintained a dignified and accepted presence within their communities, which was essential to their ongoing and accepted presence and drug use. My findings, despite the numerous inherent dangers and challenges associated with illicit heroin use in a rural setting, align with McKeganey, et al.’s (2009) assertion that reflects non-problematised drug use within the “heroin-using community.”

6.10 Chapter conclusion.

In this chapter, my primary aim was to address my first research objective, which was to investigate how people who use heroin acquire, administer and fund heroin use in rural Dumfries and Galloway. The dominant discourse in previous research has often portrayed people who use heroin as being centred around and focussed upon heroin-consuming activities and income generation to the exclusion of everything else. Scholars such as Pearson (1987), Stephens (1991) and Neale, et al. (2009) for example, have suggested that people who use heroin live dismal lives set to the metronome of fulfilling their heroin needs, from income generation, and acquiring heroin for its consumption, deepening their involvement with every “hit”. My preliminary analysis concentrated on this aspect, so I could understand the significance of identifying problem drug use, related activities and income generation. Recognising the significance of these factors is essential in understanding how they shape the identities, recovery capital, everyday practices, and subsequently, potential obstacles for recovery among people who use heroin.

My findings reveal that my participants lived largely conventional lives, integrated within the communities where most of them were born and raised. Their lifestyles were reflective of those people who did not use drugs in their communities. Participants routinely exhibited conventional behaviours and activities, for instance, participants were house-proud, purchased groceries, prepared meals, looked after themselves physically, integrated and socialised with members of their community (both people who used drugs and those who did not) and engaged in various leisure pursuits. These activities mirror everyday routines typically associated with people who do not report heroin use. People who used heroin rejected the notion that people who did not use drugs in their communities may perceive them as “lazy” due to their

unemployed status and were proactive in allaying and dispelling any potential stereotype. There were numerous challenges associated with the rural setting, such as lack of anonymity, geography and poor transport systems and risks associated with illicit drug use such as lone drug use, overdose and physical health issues, which did not dissuade the ongoing use of heroin.

"Recovery capital" positively influenced "recovery-related behaviours," such as reduced criminality and controlled drug use reflecting trends observed in the U.K. during the 1960s and 1970s (Parker, et al. 1988). In my study, only a few participants reported engaging in ongoing criminal activities other than the use or sales of prohibited drugs. Government benefits, housing, and methadone programs reduced the need for income generation from criminality. Deviant behaviour commonly associated with heroin use, such as violence and theft were not only minimised but actively condemned by my participants to reduce community censure. In contrast to Moody, et al.'s (2017) findings, recovery services were provided free by the SDAS, primarily accessed to obtain methadone and drug-use equipment. While attending these "clinics" for methadone and drug-use equipment, service professionals assessed participants' physical and mental well-being but primarily to establish they were alive and ensure their continued survival. Participants accepted their role in this "transaction", providing urine samples for drug testing, undergoing occasional physical and mental health examinations, and responding to questions (often inaccurately) related to their lifestyle and drug use. They also enhanced their "spoiled identity" by emphasising behaviours linked to addiction to elicit more resources. For their part, the SDAS staff did not enforce abstinence, but did implement harm reduction measures to safeguard and stabilise individuals' lives and attempted to change their harmful drug use and activities. "Natural recovery" and professional assisted abstinence, if they occurred, were not recorded by the SDAS, participants, or observed by me, however, controlled and self-regulated heroin use were routinely reported and observed.

"Negative recovery capital" was significant. Surprisingly, government benefits designated for disability (addiction) support were routinely identified as impediments to employment. These benefits were allocated for daily living expenses, but they were redirected toward the purchase of heroin and other substances. There was a critical anomaly here; the financial reward from state benefits outweighed financial incentives from employment opportunities within the region that were available for my participants, benefits also excused recipients from needing to seek employment. Consequently, my participants found themselves to be "time rich", time

which they could potentially use to take heroin. Contrary to my expectations, however, this was not the case. Heroin use, in the main, was found to be controlled and self-regulated and my participants were generally structured and organised in their drug use. Despite receiving government benefits, those identified as incapacitated through ill health (addiction) were positively regarded within their community, because they were "sick". A point which contrasted with social stigma negatively apportioned to people who were unemployed but considered fit to work. My participants did not associate their drug use with "self-medication", a concept closely linked with the medical model, except for alleviating potential withdrawal symptoms. My participants mostly went about their everyday lives unencumbered by the associated social stigma routinely attached to drug use and unemployment.

Despite the decline in heroin use and growing preference among younger adults for non-opioid drugs, drug-related deaths in Dumfries and Galloway, mirroring the trend throughout Scotland, are on the rise. Low-quality heroin pervades the region, however, being both inexpensive and widely available alongside other narcotics such as cocaine, amphetamine, street benzodiazepines and the most used psychoactive substance, alcohol. The mean age of my participants was higher than in other parts of the U.K. and reflects a chronic but stable community of people who used heroin. My findings indicate a careful approach among my participants when planning, buying and selling heroin, consciously minimising risk and rejecting the "chaotic lifestyle" often associated with heroin use. They rejected drug-related violence, associated criminality such as theft and generally administered heroin in their own homes, preferably with a friend. Their everyday lives demonstrate community integration, acceptance and a commitment to their own and others care. Recovery, whether through abstinence or reducing drug use, was not a priority in the lives of my participants, nor was it deemed necessary by recovery services within the region. This is not because there is a lack of recovery pathways available or accessible but because my participants did not problematise their heroin use and saw no reason for change. Nonetheless, they routinely access and accept harm reduction measures within a formal support system provided by SDAS and governmental benefits system.

Trying for a phone signal out west. Summer 2018.

Chapter 7: An exploration into the everyday practices of people who use heroin in rural Scotland.

7.1 Introduction.

To address my second objective, which is to investigate heroin use in the context of everyday practices in a rural setting this chapter will introduce a vignette. This vignette details one day spent with two key informants, a snapshot if you will, of the lives of two people who use heroin living together as a couple in a rural village. Vignettes are valuable tools used in social research to explore individual's lives, activities, and behaviours within their contextual framework. As Hughes (1998, p.381) writes they provide "stories about individuals, situations and structures which can refer to important points in the study of perceptions, beliefs and attitudes." Initially, in my analysis, I had overlooked the data encapsulated within this vignette as I sought some novel, ground-breaking perspectives on "recovery". However, upon reflection and in collaboration with my supervisor, a novel if obvious perspective was identified. One that considers the unique challenges encountered by two people who were engaged in heroin use travelling to a routine mundane everyday appointment at their local hospital in a rural setting. In this chapter, I present the vignette, exploring the unique, everyday challenges and difficulties faced by the two individuals, as one attends a routine hospital appointment for a physical health assessment related to illicit drug use. My exploration aims to highlight the impact such a challenge has on them and their everyday lives as people who use heroin.

I present findings that challenge the conventional understanding of people who use heroin. Contrary to previous research, my study reveals that individuals not only possess but actively seek out routine beyond their drug-consuming activities and income generation. They demonstrate a capacity for structure in their lives, showing the ability to plan and regulate their heroin use. I then explore and challenge the predominant assumption that people who use heroin lead inherently "chaotic lives." Through my findings, I contest this stance demonstrating that, far from embodying chaos, people who use heroin in a rural setting align their lifestyles with recovery paradigms and principles such as autonomy, dignity, and respect but do not reflect a desire for personal transformation. They integrate with their communities, leading a life that mirrored those of people who did not use drugs characterised by living lives that were arguably "normal" and "conventional".

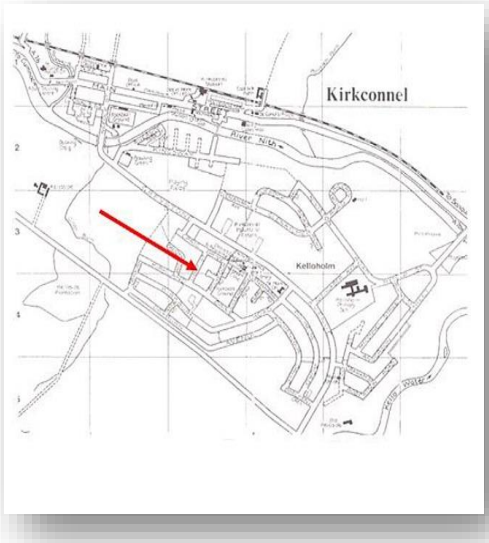
7.2 Brian and Rhonda: A Vignette.

The road from Dumfries to Kelloholm winds along the sides of steep hills, traversing tree-filled glens tracing the rushing waters of the Nith river many metres below. The views and scenery are breath-taking, the air pure and fresh and there is a complete sense of serenity. This idyllic setting, however, is punctuated by tractors, sharp bends, and pheasants darting across the road from the nearby shooting estates, which combine to slow travellers. To the rear, lorries eager to reach their destinations serve as a reminder that this is a "major" road. It is not a typical scene envisaged when en route to meet two people who have chronic and habitual heroin use disorders. I arrange to meet Brian and Rhonda, who both use intravenous heroin and I class as level 2 people who use and sell drugs (see table 1. chapter 6). They reside in a village nestled within the rural Nith Valley. I had met them once before, albeit in the presence of their "key worker", a SDAS nurse, her student nurse, and a healthcare support worker at the local medical centre. That meeting was brief, crowded, and awkward then constrained by limited time for confidential conversation. Despite these initial challenges, Brian and Rhonda invited me to meet them in their home several weeks later. The SDAS nurse expressed annoyance because I had received an invitation to meet them in their home whilst she, as their key worker of many months, had never been and incidentally never was, invited to their home.

Their home village is a small settlement, housing approximately one thousand residents, originally established in the late 1960s to accommodate workers from the now-defunct Nith valley coal mine. Nestled parallel to the village of Kirkconnel, a neighbouring village located one mile away along the A76, the main road connecting Dumfries with Kilmarnock, Ayr, and ultimately Glasgow, via the M77. Kirkconnel exudes the charm of a small traditional mining village, characterised by its stone-built miner's cottages sporting manicured gardens. Despite its modest size Kirkconnel has a high proportion of retirees among its population, many of whom worked for the local mining company. In contrast, Kelloholm has tightly packed rows of semi-detached and terraced houses, their grey or brown harled walls hide a maze of roads and pathways.

Situated amidst green hills and bleating sheep, Kelloholm feels somewhat out of place, despite this incongruity, the village is served by two shops with Brown Brothers, "*packers and distributors of cold meats"*, serving as the primary employer. Employment opportunities in the area, however, are at a premium, and are unstable, low paid and unskilled. Adjacent Kirkconnel, in contrast, hosts a more diverse range of amenities, including a pharmacy, a chip

shop (fried food takeaway), a bookmaker, a convenience store, and a pub. The nearest town, Sanquhar, slightly larger than both Kirkconnel and Kelloholm, lies approximately five miles to the south and boasts a small supermarket, a range of small shops, a secondary school and a garage.



Map1. Map 2.

Dumfries and Galloway (Map 1) - Kelloholm, (identified by red arrow) is sited adjacent to Kirkconnel (Map 2).

Despite Kelloholm's small size, locating Brian and Rhonda's home, a mid-terraced two-bedroomed house, proved challenging and took me some time to find. The people I approached to ask for directions were friendly, cheery, talkative and eager to help. The air was clear and unpolluted; there were few cars and no issues with parking as I pulled up outside their home. Brian and Rhonda's garden was neat and tidy, like those adjacent to it. While other houses had their doors open, their residents quietly conversing in the street, one particular property appeared neglected, its front and rear were strewn with old furniture, but I later learned it was unoccupied. As I readied myself to exit my car, Brian approached and explained that he had attempted to contact me to rearrange our meeting because Rhonda had secured an emergency appointment with her GP. I explained my mobile phone had no signal since leaving Dumfries, prompting Brian to suggest that I stay given the distance travelled, albeit with the caveat that our time together would be limited on that occasion.

Brian was warm, friendly, and welcoming, extending a handshake and apologising profusely about the GP appointment. He went on to explain their previous GP had returned to temporarily cover clinics whilst the new appointee was on annual leave. This had prompted Rhonda to seize the opportunity to schedule an appointment to see her erstwhile doctor. As we conversed Brian noted I was looking at the abandoned house, clarifying that its previous (non-drug-using) occupants had abruptly "moonlighted" i.e., swiftly departed due to financial difficulties, leaving the house vacant and accessible for local children to play in. Brian invited me into their home, Rhonda awaited at the door, and welcomed me with a handshake, confirming with Brian that he had explained the situation and apologising for the disruption. Their home, a local authority two-bedroomed terraced house, was warm, inviting, contemporary, furnished tastefully and tidy.

Rhonda introduced me to Linsey, a friend who was temporarily staying with them following her recent eviction from her nearby home. Linsey, aged 36, sat quietly in an armchair, draped in a large pink bathrobe, sipping her coffee. Linsey recounted the circumstances leading to her eviction, attributing it to a disagreement with a neighbour who subsequently lodged a complaint with their local housing authority. According to Linsey, her eviction was not from any wrongdoing on her part, but rather from her neighbour's employment status and timely rent payments, whilst she was an "unemployed heroin user on benefits". It is important to note that these were her perceptions, and she clarified that no allegations had been made against her.

Rhonda is in her late twenties, she was slim, dark haired and strikingly attractive. Not only is she articulate, but from our interactions, it is evident that she is very intelligent. She sits perched on the edge of her sofa, legs crossed, her hair pulled back in a ponytail, wearing little if any make-up. Clad in a black sweatshirt, black leggings and black *Nike* trainers, she reflects a casual elegance. Rhonda lives with Brian her partner; they have been together for nearly a decade. Brian also in his late twenties has a compact yet muscular physique. His attire consists of blue jeans, black *Adidas* trainers and a black V-neck jumper. His friendly demeanour is further enhanced by his constant smile, which adds a warmth to their relationship and its general ambiance.

Brian reclines against the windowsill, positioned with his back against the living room window. Unusually, the television was switched off; Rhonda had instructed Brian to switch it off when I arrived, which he promptly did, setting the tone for our time together. The only sound, apart

from our conversation, was the occasional thud of their dog, a mix of bulldog and possibly mastiff, jumping against the kitchen door behind me, where Rhonda had ordered it to "keep it out the way." It, like Brian, complied without question, without hesitation. As I glance back to ensure the door is holding, Rhonda softly reassures me, "He jist wants tae play….." However, the persistent growling suggests otherwise.

Brian mentions that he has always resided in Kelloholm, prompting Rhonda to interject and explain that she relocated to Kelloholm seven years prior to be with him. They have an obvious and deep connection and I notice Brian frequently deferring to Rhonda for guidance and support throughout our discussion. Both Rhonda and Brian had a history of habitual heroin use before they met. Their relationship evolved when they "*worked"* together selling and distributing drugs in Dumfries. Despite the challenges posed by their shared substance use disorders, their relationship has endured and remained stable, a scenario not uncommon amongst my participants. However, studies such as Quaglio, et al.'s (2014) indicate such relationships impede change, as one partner's heroin use can influence the others behaviour. Rhonda, in her quiet tone, proceeded to share insights into her life in Kelloholm with me:

> "It's a fuckin' shithole, (rolls her eyes) fuck all here, fuck all happens….a could fuckin' blow it up and the fuckin' hole wid look better….no thit onybody wid notice or gie a fuck!"

She lamented with an air of resignation. Brian interjected half-heartedly, "it's no' that bad…." Rhonda raised her eyebrows at him sceptically. When I inquired why she chose to remain in a town she clearly disliked, she simply shrugged her shoulders in response. Brian glanced at her and redirected the conversation.

Neither Brian nor Rhonda explained their choice to live in rural Kelloholm, where they lacked anonymity and where their heroin use was common knowledge. However, information obtained from other sources suggested they fled Dumfries to evade persecution from rivals who sold and used heroin, following the incarceration of Rhonda's family (parents and brothers) for heroin "dealing." Rhonda allegedly used her family "status" to orchestrate theft, violence, and acts of humiliation against people who used heroin and rivals who sold drugs. She purportedly employed both heroin and monetary incentives to manipulate her associates (not Brian) to carry out her orders.

Rhonda managed to avoid incarceration as she was not directly involved in violent acts, although she faced a fine and was sentenced to "community service" for selling drugs. Alone and cut off from the protection and status afforded by her family, she felt vulnerable and was allegedly threatened with violence on several occasions. The 30-mile distance between Kelloholm and Dumfries provides Rhonda with a sense of security, yet she still perceives her safety to be at risk. Despite a desire to return, she refrains from going back to Dumfries, only making "essential" visits with Brian whom she affectionately describes as a "lover, no a fighter." Brian elaborates on his role as a "part-time runner" for Rhonda's family in Dumfries, and that their relationship blossomed when they "worked" together. "She hud a hingin' eye fur me fae the start" [laughs]. Brian's responsibilities included collecting drugs from suppliers and delivering them to members of Rhonda's family for weighing and packaging. Additionally, Brian was expected to distribute various drugs to their "customers" and return the money to the family, receiving cash and/or heroin in exchange.

Both Brian and Rhonda disclose they use heroin daily, primarily obtained from a "dealer" located in another village. They also utilise a "go-fur" [go-for, a messenger] to Dumfries to procure heroin. On rare occasions, they travel by bus to Kilmarnock, Ayr, or Glasgow to purchase heroin and other drugs in bulk, for personal consumption and to sell to others in their community. A "go-fur" buys and delivers drugs for the purchaser and is normally compensated, with either heroin or cash. However, there is always the risk that the "go-fur" may abscond with their money, use the heroin themselves, disclose Rhonda and Brian's location to third parties, or, if apprehended by the police, seek leniency in exchange for information about people involved in the drugs deal. The consequences of such a risk to Rhonda and Brian are dire. They would then be left to endure "rattling" [withdrawal symptoms] if they do not receive their heroin, along with the challenge of sourcing extra funds to purchase alternative heroin. While purchasing heroin in a city or large town is more economical due to bulk purchases, it exposes them to risks they are not used to in their own community such as theft and violence because they are not regular buyers or being arrested by the police because they are not known to them. And with prior convictions for selling and trafficking heroin, both expect to have "the key thrown away" (lengthy custodial sentences) if apprehended.

Brian and Rhonda emphasise the need for caution when selling drugs, citing concerns that the "resident dealer wid no be happy". They explained that if he knew about their exploits, he could

potentially stop selling heroin to them, increase his prices or even report them to his own supplier, who may consider their actions unfavourably. When I expressed an interest in meeting him, Brian quickly retorts "no can do", as he recently got caught in possession of a significant amount of heroin after an anonymous tip-off. Given his prior convictions for possession and distribution of heroin, Brian was convinced he would receive a lengthy custodial sentence, which indeed materialised (imprisoned for six years). This turn of events presented an opportunity for Brian and Rhonda to step into the role and advance their identities as level 2 drug suppliers for the area. However, they are coy about the circumstances leading to his arrest. Co-operation with the police is deemed a high-risk strategy, becoming an informant invoked a pariah status and a serious risk of violence from other people involved with drugs.

Rhonda disclosed that she had "injected [heroin] daily" for "nearly 13-years". Brian transitioned to injecting heroin when he was 22, having previously smoked it. He states he mostly "smokes heroin now" because they both use "street benzos". Rhonda injects twice per day and joins Brian in smoking heroin late in the evenings. Brian is less forthcoming about his heroin consumption, indicating that it fluctuates depending on how he is "feeling". Both Brian and Rhonda receive 40ml daily dispensed scripts of methadone via SDAS. Their prescription methadone is a relatively low dose due to their ongoing heroin use and concerns about accidental overdose. However, should they choose to reduce their heroin use, their methadone prescription would increase. Brian and Rhonda express their intention to continue to use heroin, methadone, and benzodiazepines, despite the support and resources available to them from SDAS and the very real risk and harm indicators associated with drug use.

On average, we calculate their weekly expenditure on drugs to be £350 (£1,400 per month), while they receive £450 per month of disposable income from benefits. The realisation of this amount seems to surprise them, as Rhonda remarked "a nevur thought it wis that much….did you Bri?" "Naw…" (Whistles and raises eyebrows). The shortfall in funds was supplemented by Brian's occasional cash-in-hand work at the local shooting estate, where he engages in such tasks as beating (driving game birds for guns), poultry rearing (including pheasants, partridge, and grouse) and selling heroin. Brian earns £25 for an 8-hour day, and he and other residents walk several miles to the estate to avoid detection from benefits agencies investigators. Once there, they are transported to shooting locations or the aviary by estate employees. Brian, explained that he enjoyed his job, remarking, "gets me oot in the fresh air….an' gies Rhonda some peace n' quiet, eh?" (Laughs).

Brian and Rhonda voiced a regular frustration among my participants: the inferior quality of heroin. They believed the heroin available in rural settings contained more cutting agents compared to urban areas, because it passed through multiple drug suppliers before reaching rural areas. However, Billy, who sold drugs from Dumfries, refuted this claim, bluntly stating, "It's shit tae start wi". The perceived inferior quality of heroin, coupled with an unfounded uncertainty surrounding its availability led Brian and Rhonda to adopt a stockpiling strategy for their drug supplies, indicating a degree of controlled use. The inferior quality of heroin also arguably exacerbated their drug use, contributing to an increase in poly-substance use, including street benzodiazepines, counterfeit "Valium" (Diazepam) and "Xanax" (Alprazolam). The uncertainty regarding the purity of both heroin and street benzodiazepines, especially combined with prescription methadone and alcohol, resulted in Rhonda experiencing three life threatening separate overdoses. She admitted to having no knowledge of the strength (purity) or ingredients of the substances she consumed, relying on Brian to take care of her. Rhonda vividly recalled her most recent overdose:

> "Ma heart stoaped, eh Brian [Brian nods in agreement]. They hud tae stert it in the ambulance [using a defibrillator]…..fuckin' close call that yin. A wis oot [discharged herself against medical advice] later that night though, they widnae gimme fuck all [methadone] and a wis rattlin' [due to a naloxone injection]. That's the third time [overdosed] that's happened."

Rhonda had quickly returned to Kelloholm via taxi to meet up with Brian just a few hours after narrowly surviving a heroin, methadone and benzodiazepine overdose. She attempted to rationalise her overdose stating she "shouldn't have been drinking vodka at the same time".
The unpredictable purity of the heroin and other illicit drugs exacerbates the risk of overdose: too pure, means a "one hit" overdose; not pure enough, leads to a second (dirty) "hit" in quick succession, the accumulation of both increasing the likelihood of overdose. Then there was the addition of other drugs and alcohol. As with all the participants I encountered in Dumfries and Galloway, Brian and Rhonda's substance use involves multiple drugs, including heroin, methadone, benzodiazepines and occasionally cocaine alongside alcohol. This trend aligns with research by Darke and Zador (1996 p.1765) which noted that "the presence of other drugs (primarily central nervous system depressants such as alcohol and benzodiazepines) being

commonly detected at autopsy" whereas deaths solely attributable to heroin have been and remain surprisingly uncommon (Darke and Zador, 1996; Dolan et al. 2021).

Brian and Rhonda collect their daily dispensed methadone after 9am from the only pharmacist in Kirkconnel, timing their visit to avoid children waiting close by for their school bus that transports them to the local secondary school in Sanquar. The pharmacy is small but quiet at that time in the morning, except for a few other individuals receiving their methadone prescriptions, the pharmacy also serves as their primary contact to SDAS recovery services. There is no privacy booth, so they patiently wait and then take their methadone at the counter in an open area of the pharmacy, adjacent to two large windows that overlook the main street, bus stop and car park. Brian and Rhonda disclosed that if there is someone else inside, they prefer to avoid the potential "embarrassment" of being watched having their "seen (daily) script". Brian elaborates:

> "Am no trusted tae bring Rhonda's [methadone] up the road, they ken me too well [don't trust him] so she hus tae go an' git it. She wid fuckin' dae me if a gote it an' yased it masel though" [laughs].

Brian is unaware, as no one has explained to him, that the dispensing of methadone is not based on trust. In accordance with controlled drugs policies, individuals with a prescription for methadone must be physically present for its dispensing and then they are watched whilst it is consumed on the premises. This places individuals in an undignified position, but is the daily reality faced by most people who use heroin in Dumfries and Galloway.

As our discussion unfolds, I confess to both Rhonda and Brian, that their appearance and demeanour don't match my preconceptions of people who report chronic heroin use. They appear physically healthy, well-kempt, dressed in designer apparel, (*Nike, Adidas, Tommy Hilfiger),* and their home is tastefully furnished, clean and orderly. They look content and happy prompting Brian to smile and thank me for the compliment whilst expressing genuine surprise at it. He then posed a loaded question, "When wis the last time yi 'hink a took gear?" Aware of the delicate nature of the question I go along with Brian and proffer a guess. I noted a "gear box" (a container for heroin and related paraphernalia) at Rhonda's feet, but the air is clear and free from the acrid smell of heroin I had become accustomed to. Linsey is also present, and I wrongly assume Brian and Rhonda would not share their heroin with her.

However, I do observe slight signs of drowsiness, perhaps a hint of "gouching," as they call it, which suggested recent use. “Yesterday”, I proclaim. Both smile and Brian states triumphantly, “Just hud a .2 between us.” The quantity of heroin consumed by Brian and Rhonda is substantial, especially considering their recent intake of methadone and benzodiazepines. Linsey, on the other hand has only had a “smoke”, explaining that Brian provides it to her free as they are friends.

Due to her recent eviction, Linsey does not have a permanent address required to receive a methadone prescription from the SDAS. If she were to declare that she is living with Brian and Rhonda, their benefits would be reduced as she will be classified a “tenant” and be expected to contribute financially toward her accommodation. Additionally, she would lose her “priority” status on the local authority’s homeless accommodation list, being deemed “housed,” potentially resulting in a decrease in her benefits. Thus, Linsey relies on Brian and Rhonda not only for drugs to alleviate potential withdrawal symptoms but also for accommodation and support.

Brian and Rhonda’s capacity to manage and regulate their heroin consumption enables them to live and function unhindered within their local community. Despite people within their community being aware of their drug use, concealing it maintains an air of respectability, distancing them from the stigma associated with being labelled for instance as “giro junkies”. Rhonda qualifies this by explaining:

> “We ur respectable, we dinnae go robbin’ people or stuff we yase [take heroin] aye, but its jist tae function, tae be normal, we git nuthin’ fae it now [Brian nods his head in agreement].”

Her answer elicits an almost immediate and unconsidered question from me: “So, why not just stop?” There is an unexpected silence in the room. They look at each other and then towards Linsey. I realise that I have encroached into sensitive territory, unwittingly making them uncomfortable. After a lengthy pause, Brian breaks the silence. “It’s no’ as easy as that….” His words hung in the air unanswered as to why it is not as easy, or indeed why they do not stop, no explanation, just silence. There need to use underpins the “addictive” nature of heroin use and their dependency upon it. Both Rhonda and Brian blink slowly, the effects of the heroin they have consumed becoming more evident as time passes and I consciously watch for it.

Rhonda winced as she uncrossed her legs, prompting me to recall her telling me about her deep vein thrombosis (DVT) and ulcer. Concerned, I ask if she is OK, drawing upon my nursing background and familiarity in the management of DVTs and leg ulcers. Despite the analgesic effects of methadone and heroin, Rhonda complains of being in pain, which surprised me. She explains that while the DVT has improved, the ulcer on her inner thigh has not healed. She sheepishly admits to injecting into the ulcerated area as it serves as an accessible vein because others are becoming inaccessible. Rhonda's keyworker from SDAS had described Rhonda's ulcer as a "shallow hole about the circumference of a female's fist, but that was about three weeks ago when I last saw it." Without proper medical interventions, ulcers can worsen in depth and size, becoming prone to infection. In the absence of a proper medical dressing, Rhonda "dressed" it with a sanitary towel, received free from SDAS. This increases the risk of infection and worryingly indicates that she is not being effectively treated.

To have her ulcer treated effectively she needs regular medical appointments. However, Rhonda stubbornly refuses to attend her GP, stating "a dinnae like him" opting instead to self-medicate with more heroin to alleviate the pain. The pain hampers Rhonda's mobility, but her ability to mobilise within her locale remains essential. Despite the discomfort, she continued to walk the mile from her home to the pharmacy each morning to collect and take her methadone. This journey normally took approximately 20 minutes but took Rhonda up to "an oor there n' back." The cost of a taxi every day proved prohibitive. Brian, however, had "obtained" a bicycle. The bicycle enabled Rhonda to freewheel downhill from their home to the pharmacy, easing one-half of the journey. Brian then assisted her on the return journey, pushing her back on the bike as far as he could to ease Rhonda's pain, allowing her to walk the remainder of the way. Rhonda's physical infirmity further complicates her life because she is unable to seek and gain employment. Additionally, she refuses to attend her new GP, who could confirm she was medically unfit, thereby opening further avenues for additional financial support through illness-related benefits such as PIP and potentially a "take-home" (weekly) prescription. I advise Rhonda to discuss her situation with her old GP and explain the challenges she is facing.

Rhonda recalls their previous experience when they sought medical attention from her GP about her ulcer and DVT, only to be referred to Dumfries and Galloway Royal Infirmary (DGRI), located over 30 miles away for a leg scan. Brian and Rhonda do not have a car, the

cost is prohibitive. A car, however, is crucial for overcoming the logistical challenges within rurality. To get to DGRI for Rhonda's 9am appointment, Rhonda and Brian had to be meticulous in their planning. Both arose at 6am, to "score", to inject heroin intravenously, which is several hours from when they normally administered heroin. If they did not, they would "rattle" (experience withdrawal symptoms) during their appointment. It is essential that Rhonda and Brian return to Kirkconnel before 5pm, as this is when the pharmacist closes. Missing their daily script of methadone would require them to wait until the following morning for their prescription and the use of more heroin to compensate. To ensure they wake at 6am, they must refrain from taking drugs after 9pm the previous evening. Typically, they use benzodiazepines or a "toot", a smoke of heroin, to help them sleep around 11pm. Taking drugs at their normal time would have meant they would have failed to awaken at their allotted time the next morning. The restlessness of withdrawals, however, ensures they did not need an alarm, because their sleep is broken when they did not adhere to their usual drug regime.

At 6am, they want to "cook", to prepare their heroin for injection, but resist, fearing the temptation of an available syringe full of heroin. Instead, they used this time to wash and dress. They skipped food because they have no appetite when they need a "hit". At 6.30am, they consumed extra heroin to sustain them until the afternoon and their methadone script, which could not be accessed at their usual time, because the pharmacy did not open until 9am when they would be in Dumfries. However, administering heroin too early meant they would "gouch", and succumb to its effects, probably falling asleep and missing their bus. Thus, they fought off the cravings as long as they could. Conversely, if they did not take enough heroin, they would experience withdrawal symptoms, becoming increasingly restless and unsettled as the day progressed. They had to carefully judge the appropriate amount of heroin to take in the absence of their prescription methadone, or they would be tempted to acquire heroin in Dumfries. Rhonda explained that "Brian disnae like tae score in the toon" [Dumfries] a sentiment Brian readily agreed with, stating, "Fuck naw, avoids at aw costs" [laughs].

Although they did not explicitly explain the rationale for their decision, choosing to purchase and use heroin in Dumfries posed a serious physical risk to Rhonda in the form of reprisals from unresolved conflicts from other people who use heroin. Additionally, acquiring heroin in Dumfries would require them to bring their own injecting equipment, or use equipment provided by the person who sold them drugs which could easily be contaminated. They would also need to use the seller's residence to prepare and administer their heroin. Given the

uncertainty of the strength or purity of the heroin, there was the potential for “gouching” and falling asleep, rendering them vulnerable to theft or physical assault. Furthermore, the effects of the heroin could impair their ability to travel back to Dumfries town centre to get a bus home, potentially resulting in a missed appointment with their pharmacist. The pharmacist would then notify SDAS of a "missed script," potentially necessitating additional appointments and urine screening at the SDAS unit in Dumfries. Depending on the results, their methadone prescription could be suspended, leading to further assessments by the SDAS and potentially a reduction in their methadone dosage. There was also the risk that the heroin available in Dumfries was of poorer quality than they were used to, requiring them to spend additional money on further “hits” or risk returning home experiencing withdrawal symptoms, further depleting their finances. For Rhonda, smoking heroin is considered a “waste o’ money an’ time” as it did not provide the sustained effect she needed. The number of people who sold drugs in Dumfries was limited for Brian and Rhonda, leaving little choice or anonymity compared to urban settings, making purchasing heroin there a high-risk and costly strategy.

Calculating their heroin use so early in the morning was therefore imperative but presented a significant challenge for Brian and Rhonda, especially after a broken night’s sleep and feeling edgy as the impending “rattles were in the post.” Too much heroin in the morning and there was the ever-present danger of overdose and death. Fortunately, Kirkconnel has a paramedic residing locally, who keeps his ambulance at his home while on-call. Luckily for Rhonda immediate medical assistance was available during her three previous overdose experiences. Otherwise, there would have been a 40-minute “blue-light” drive from the Dumfries ambulance station to Kelloholm.

Brian pre-ordered and prepaid a taxi to secure the driver's services, to drive them the one mile from their home to the bus stop in Kirkconnel, stating “he willnae come unless a square him up afore hand.” March meant it was cold and dark at 6.45am, making the journey even more challenging for a partially immobile Rhonda. There is one taxi service available in Kirkconnel, charging a fixed rate of £7.50 for a one-way trip from their home to the bus stop. Brian pointed to the taxi base, a terraced house across the street ““er it’s ower there” indicating its location with a nod of his head. Although there is a bus route passing through Kelloholm it is later in the morning and the bus stops too far away for Rhonda to walk, leaving them with little choice but to rely on the taxi service. The taxi driver, who they knew well, is pleasant and familiar with Brian and Rhonda's circumstances and drug use. However, due to previous instances

where he was not paid on time, or when Brian and Rhonda had not shown up, the driver requires payment upfront before picking them up. Rhonda acknowledges this, stating he "disnae trust us….no that a blame him".

The bus to Dumfries arrives at 6.57am; with the next one scheduled an hour later. It costs £4.50 each return. Brian and Rhonda benefit from fare concessions as recipients of "ESA" provided they presented proof of their unemployed status to the driver to get the discount. Rhonda explains:

> "We git the seven o'clock bus, cheaper than the train, a huv tae show the driver ma caird [unemployment status], fuckin' disnae even acknowledge yi when yi show um and he makes aes show um aw the time and a ken 'im!"

The effect of their heroin became evident when they boarded the bus, so they sought refuge at the rear to evade the scrutiny of other travellers. There, they lightly dozed as the bus wound its way to Dumfries. The bus takes just over an hour to travel the 30 miles, making numerous stops as it meanders through villages en route. Brian and Rhonda alighted at the Whitesands; the solitary stop the "express" bus makes within Dumfries. Known locally as a gathering spot for people who use drugs and alcohol, the Whitesands has 3 stances serving as the primary bus depot and interchange for bus transfers. The only facility is a public lavatory, with a harsh ultra-violet light blaring out installed to deter individuals from locating veins for injection in its shelter. Adjacent to the bus shelters is an underpass created by a centuries-old bridge over the river Nith that provides shelter from the elements for rough sleepers and "drinkers". Public drinking, however, was prohibited by local bylaws preventing the consumption of alcohol in designated public areas some years previously, and I never encountered rough sleepers.

Buses are common (if unwitting) heroin mules used by "go-furs" and "runners" to transport heroin from suppliers to various recipients throughout the region. So common, in fact, those runners sometimes make mistakes:

> "Did you misplace a suitcase with £6,500 worth of drugs in it? Great news, it's been found, and we have it at Dumfries Police Station."

> "Just pop in, tell us what's inside it, where you left it, and we will be happy to return it to you!"

This Facebook post appeared on Police Scotland's Dumfries page following an incident where a "runner" accidentally left his suitcase behind on a bus (he was "gouching" following a trial of his cargo). Fortunately, a vigilant member of the public handed it into the bus company's lost property office.

The early morning, thankfully, meant Brian and Rhonda were less likely to meet anyone who knew them in Dumfries, but it was also a major concern. The effects of their heroin are at its peak, making them both vulnerable to "gouching" and impairing their cognition and reaction times. The Kirkconnel bus was scheduled to arrive at the Whitesands at 8am, but delays of 20-minutes were not uncommon due to traffic (tractors and HGVs). Additionally, the bus functioned as a school bus, ferrying children from villages and outlying farms to schools. I inquired whether they were noticed or labelled by people, or if the children harassed them. Brian shook his head and responded:

> "Fuck naw…..except when the kids ur lookin' tae score…[he laughs] am only jokin' [he puts his hands up in protest]. Naw the kids ur fine nivur bother us, naebody roond here does."

His response surprised me, and it sits contrary to findings from scholars such as Goffman (1963), McGinty, et al. (2019) and Yang, et al. (2017), who commonly associate stigma with people who use heroin. Despite their local community's awareness of their substance use, Brian and Rhonda did not experience ostracism or social exclusion in Kelloholm, a common theme within my data. Their lifestyle and behaviour, in their opinion, do not draw negative attention. They mentioned "rare" instances of verbal abuse, primarily from individuals they referred to as "wee schemie bastards", people with whom they had disagreements with regarding drugs or money, who occasionally derogatorily call them "junkies".

Their bus from the Whitesands to the new DGRI departed promptly at 8.10am. On this occasion, however, their bus from Kelloholm was late so they had to wait until 8.30am for the next bus from the Whitesands stop. The Whitesands bus stops are situated in an open aspect beside the river, south of the town centre, offering no concealment for Brian and Rhonda. The

shelters are constructed from clear Perspex, with a low wall that doubles as a seat, the only nearby café on the opposite pavement was closed until 9am. Rhonda's mobility difficulties rendered walking any distance unfeasible, so they sat, hoping to remain unseen. Coincidentally, the bus stop serves as the primary public transportation hub for the west of Dumfries, Rhonda's old stomping ground.

The round trip to the newly constructed DGRI, located on the outskirts of Dumfries to the west, amounted to £2 each for the 15-minute journey covering 3 miles. Upon arrival, they waited for their appointment. The appointment letter advised them to "allow up to 2 hours" from the scheduled appointment time. Rhonda's appointment was scheduled for 9:05 a.m., and during the subsequent two-hour wait, they were directed to several departments before finally undergoing an ultrasound scan for her suspected DVT. Reflecting on the experience, Rhonda said:

> "Fuckin' place is massive…it's like an airport. A hud tae walk miles, ma leg wis agony, they jist kept sendin' us tae different places bit naebody looked at me. They treat yi like shite, lookin' doon their noses, nae fuckin' manners…. then a finally gote a scan 'hing."

The new hospital is an expansive, modern, state-of-the-art building, with a long foyer, set over 3 miles from Dumfries town centre. It is one of two hospitals in the region the other being 75 miles away in Stranraer, further than the principal hospital serving the city of Glasgow. Quite how they knew Brian and Rhonda had substance use disorders was uncertain. Brian took the initiative and appropriated a wheeled chair from the hospital's foyer, pushing Rhonda to her various destinations when she became too sore to walk. Rhonda's scan, from start to finish, lasted approximately 5-minutes. Following the scan a receptionist instructed Rhonda to make an appointment with her GP to obtain her results and potential treatment options. With their tasks complete, they were free to depart. It was 11.05am, the same time their bus to Kirkconnel departed. The subsequent bus was not due until 12:05pm and so they waited in the hospital sitting area. Eventually, they decided to spend £9 on a taxi to the bus stop at the Whitesands, ensuring they caught the 12.05pm bus home.

The bus, however, was late, and departed at 12.15pm arriving at Kirkconnel at 1.20pm. Subsequently, they faced a wait until 2pm for the pharmacy to open (closed for lunch between 1 and 2pm) to collect their methadone. By this time, they were both growing increasingly

restless. Brian described the experience of waiting to collect his methadone, noting, “everybody kens whit yer waitin’ oan. And they cun….hmm people thit work there see yer waitin’ so jist take thur time.” Rhonda added, “it’s fuckin’ embarrassin’ but SDAS will nae gies a hame script.” The reason for which was not forthcoming, but a daily observed methadone script necessitates Brian and Rhonda’s forced engagement with services, mitigating the risk of overdose which was more likely if multiple doses of methadone were dispensed. The pharmacist notifies SDAS if Brian and Rhonda fail to collect their scripts, prompting SDAS to telephone Rhonda to ensure they are both well and alive. There is nowhere for them to go in Kirkconnel, it literally comprises a single street along the main A76 thoroughfare, so they opt to stand outside the pharmacy rather than returning home only to make their way back for their methadone at 2pm.

Having been observed taking their methadone, they order a taxi from the pharmacist to their home. Rhonda explained, “I wis too sare tae move, and it’s only a fiver back.” They waited for the taxi to arrive and paid the fare upfront, arriving back at their home at 2.30pm. Rhonda and then Brian, because he is “cooking” for Rhonda, indulged in a “little” extra heroin. They did not normally use heroin at that time of the day, their routine is normally strict, but it eases the pain in her leg and relieves the exertions, tensions and stress of the day. Brian injects heroin because Rhonda does. There are inherent risks to shared heroin use such as overdose, reduced incidence of recovery and physical ill health from shared equipment but there are also benefits, such as physical safety and reduced risk from overdose.

The outlay for the trip to the hospital amounts to £36, Brian also forfeits the possibility of £25 from his "job" due to his absence. They forego food but did spend an additional £20 on heroin for the morning and afternoon “hits” bringing the total expenditure to £81. However, their total weekly benefits amount to £107 each and the time spent for a five-minute scan was approximately eight and a half hours, covering over 70 miles throughout the day. Rhonda does not know her scan results; she has not visited her (new) general practitioner and has not seen him since February 2018, we are now well into May 2018. She expressed that she felt stigmatised by him because of her heroin use. Rhonda voiced her anger and frustration, stating:

> “He’s an ignorant bastard, he wis fine until a telt him aboot ma methadone then he chinged (snaps fingers) like that, became aw cauld and hostile. Am still a person nae matter whit a dae or dinnae dae”.

Rhonda did not receive treatment for a potentially life-threatening condition. Rhonda and Brian reminded me that they needed to attend their GP appointment, their old and a trusted doctor was covering “open surgery” (open appointments) during the new doctor’s absence. I offered to drive them to the medical centre in my car, but they declined. Rhonda planned to free-wheel her bicycle, and Brian intended to push her back home. Although I offered to wait for them, they explained they planned to purchase heroin after the appointment, and their supplier would not welcome my presence. They did invite me to meet them again at the end of June, and I watched with a mix of concern and amusement as they laughed and free-wheeled their bicycle down to the medical centre.

7.3 The hospital appointment.

Brian and Rhonda’s vignette candidly highlights the everyday challenges associated with heroin use in rural settings. What seems like a mundane everyday occurrence such as a routine visit to a healthcare facility takes on a whole new dimension when habitual heroin use, and rurality are factored in. Compared to urban settings, where access to essential hospital appointments may be more straightforward and arguably hold fewer challenges for individuals, whether they use drugs or not, rural geography introduces prolonged travel times and increased costs. This raises pertinent questions about how people who use heroin, routinely associated with "chaotic lifestyles" and unregulated use, navigate routine yet crucial healthcare appointments. Brian and Rhonda's circumstances offer a valuable insight into the strategies employed by people who use heroin to manage their everyday practices, their healthcare, and consequently, their recovery.

The urban, Tuan (1976) writes, has a multitude and abundance of structural resources offering a plethora of choice to its residents. Take Glasgow, for instance, which has five large hospitals within a 10-mile radius, alongside numerous smaller healthcare facilities. This array of services operates flexibly, providing a broad range of services catering to the diverse needs of its large and heterogeneous population. Consequently, a referral from a general practitioner to a hospital for a routine scan, for example, arguably entails less disruption and impact on individuals I urban settings compared to their rural counterparts. Costs are less, with healthcare facilities easily accessible on foot or via regular and inexpensive public transport. The application of similar circumstances to rural actors reveals “unperceived power structures and discursive networks” (Prieto, 2012, p.75) that shape the perceptions and expectations of its inhabitants.

This highlights many challenges stemming from rural settings including resources, geography, and individual expectations, which often go unnoticed but are considered the "norm" to those residing there. Disparities between urban and rural settings highlight one of several reasons why urban settings attract people who use heroin, while simultaneously questioning the attraction rural settings hold for people who use heroin.

Due to low population demands and geography, The Scottish Government (2018) identifies rurality as a barrier to the establishment of structures such as recovery services, with the recruitment of specialist staff in these areas a significant challenge. Gieryn (2000) identifies this phenomenon as "rural drag", which he defines as notable disparities between rural and urban areas, where rural settings lag urban settings due to "gaps" in technology, transport, and infrastructure investment. Rural drag can slow progress and development within rural settings making it difficult for them to stay apace with urban settings regarding services, economic development and quality of life. Mitigating this phenomenon, he suggests, means addressing these gaps through increased investment, improving transports infrastructure and the application of novel technologies. Redressing the imbalance between rural and urban domains would influence social perceptions of the respective spaces. Mungal (2005) wrote that the lack of research on the impact of centralisation of resources on rural actors requires ongoing assessment but argues that cost-cutting in structures and services within rural settings (although financially justifiable), contributes to "rural decay", a transformation from agrarian to urban-industrial economy, rather than the elimination of "rural drag". This decay is arguably challenging to reverse and amplifies factors commonly associated with drug use such as poverty, lack of opportunity and hopelessness.

Johnson and Scott (1997) identify economic influences as crucial to rural decline, leading to an environment that has structures and services far inferior to those within the resource-rich and densely populated urban areas. This, in turn, impacts the socioeconomic status of rural populations, with Judd, et al. (2006) attributing socio-economic disadvantage to many inhabitants as a direct result of rural living. This impoverishment is routinely considered a cause of heroin use but is not perceived as problematic for rural residents like Rhonda who stated "I huvnae really thought aboot it" when asked if she felt disadvantaged living in a rural area.

However, socioeconomic disadvantages in rural settings also correspond to positive living conditions, highlighted by Sanderson and Polson (1942), Donnermeyer (1997) and Wacquant (2008). They all report higher standards of living in rural settings, extending to lower property costs, reduced pollution, a slower pace of life, a sense of community, and lower crime rates, contributing to better, more integrated communities and mental health services. These factors were routinely observed throughout my study and are positively referenced in the literature, particularly in relation to change and recovery pathways. They did not, however, appear to encourage engagement with recovery among my participants.

The nature of rural environments implies that there is typically no necessity for multiple structures or resources, there is simply not the "footfall" to justify them. In my study, rural towns often had only one pharmacy and usually access to one medical centre, due to their low populations, which Mungal (2005) and Landers, et al. (2013) identified as inevitable, due to cost considerations related to footfall and usage. My findings suggest that the limited resources compel all individuals to use ***the*** local facility and service, or travel to urban areas where resources and competition are more abundant. As there are no immediate alternatives within the local vicinity, this makes anonymity and confidentiality difficult to attain and maintain.

Allow me to explain. In my research, I discovered pharmacy staff and customers, for example, all reside in the same area. Professional boundaries are juxtaposed to but intersect kin and friendship ties, increasing the risk of confidentiality breaches. Personal information, albeit unwittingly and unintentionally, can be easily disseminated among the local population, leading to the formation and application of assumptions. This process Philips (2002) argues, contributes to the shaping of social identities within rural spaces and how, according to Stephens (1991), rural individuals are socially constructed and located. This dynamic is certainly reflected in my data, with Rhonda candidly stating, "everybody kens everybody's business roond here." Labels such as "addiction" and "addict" can therefore be imposed and assigned by people who socially construct the identities of others based solely on hearsay and preconceived notions.

Rurality according to Foucault (1980) entails power relations between people, structures and function similarly to urban areas. However, Harper (1987, p.309) argues:

> "The resident population possesses specific behavioural patterns, typically aligned to the socio-economic characteristics of the households and the density and size of the development".

Consistent with this perspective, Brian and Rhonda exhibit specific behaviours often associated with heroin identities, but behaviours that are also consistent with other (people who did not use heroin) actors within the rural community they share, which are influenced by rurality itself, which Relph (1976) indicates to be of equal importance. Living in a rural area means Brian and Rhonda lack anonymity and have nowhere nearby to relocate to and escape their social circles, resulting in the perpetuation of their heroin-associated lifestyles, which are constant, reinforced, conspicuous and "known" within their close-knit community. In this context, there is little need to conceal drug-related behaviours or activities because they are not secret as Brian stated, but that does not equate to "acceptance" of their behaviours and activities by people who did not use heroin from their community. Cloke, et al. (2000) draw a comparison of the deviant behaviours and lifestyles in urban settings, noting that a significant number of actors in urban settings become virtually invisible to society. Urban society, they comment, is conscious of the physical presence of deviant and spoiled identities often associated with homeless people, beggars and those with substance use disorders who are physically visible to them. However, urban society has long since moved to accept these individuals as part of the construct and fabric of urban living rendering their physical being "invisible" within an urban landscape.

People who engage in heroin use from a rural setting actively respond to the challenges of rural living by, for instance, consciously striving to integrate into their communities and maintaining social and familial ties. In doing so, they challenge the dominant constructs and prevailing stereotypes that characterise them as chaotic, deviants and lacking control over their heroin use. They consciously regulate and moderate their "addiction" associated behaviours and activities to align with societal norms. This adaptability would arguably be unattainable if their addiction was biological in nature, for instance. Brian and Rhonda exemplified this when they engaged in complex and advanced planning to attend an arguably mundane, everyday hospital appointment. It was routine for them, and they gave it little consideration "we jist get oan wi it" as Brian explained. This ability to change to meet opposing demands of their heroin use and physical care needs is closely tied to a key aspect: self-regulation, involving controlled heroin

use. An aspect, not routinely associated and often overlooked in the perception of habitual heroin use, but positively aligned with recovery pathways, as explored in the following section.

7.4 Controlled heroin use? Self-regulation in a rural setting.

Rhonda and Brian's hospital appointment highlighted a crucial rural phenomenon: the necessity to control and self-regulate heroin use over a sustained period to overcome rural challenges. Brian and Rhonda meticulously planned every aspect of their hospital appointment from the purchase and administration of heroin to its regulated use the day before and on the day of the appointment. Rhonda also insists on punctuality, she considered it courteous thus ensuring they traversed the many vagaries of the region's rural transport system to be on time for her appointment to address her health needs. These actions contradict Burnham, et al.'s (2019) claim that suggests people who use heroin have poor engagement with healthcare providers; they do align with recovery principles, however.

Rhonda could not rearrange her appointment, requiring attendance as early as possible to avoid encountering people who used heroin in Dumfries and ensuring their return to Kelloholm by 5pm to avoid missing their methadone. Her actions demonstrate forethought, planning, and organisation, necessitating control and self-regulation of heroin, she had the forethought to understand and traverse her prevailing challenges. Not only are these behaviours inconsistent with those attributed to addiction resulting from biological or pharmaceutical factors, but they also contradict prevalent discourse (Weinberg, 2022; Tweed and Rodgers, 2016; Parker et al., 1998; Rosenbaum, 1981; Warburton et al., 2005) portraying people who use heroin as having chaotic lifestyles and an immediate need for heroin gratification. Despite having heroin, access to more, money, and injecting equipment, Brian and Rhonda maintained their regulated use. This next section delves into their controlled heroin use.

Bakhshani and Hossienbor (2013, p.40) define self-regulation as "an important personality process through which individuals control their thoughts, feelings, impulses, needs and behaviours with adaptive responses to surrounding challenges made easier by self-regulation." Rosenbaum (1981, p.72) suggests that a person using heroin is "…an individual who is desperate (and) will not have the patience to think out their moves, to execute an ordered plan." Controlled and regulated heroin use is not positively situated within the construct of chronic, habitual "heroin users" stereotypes according to Rosenbaum. Stallwitz (2012), on the other hand, contends that being able to regulate heroin use is considered necessary to prevent a

descent into chaos and is a crucial change toward a recovery pathway and a drug-free life. My participants did not use regulated and controlled heroin use as a gateway to recovery pathways.

Consistent with Stallwitz's perspective, I routinely observed controlled and self-regulating behaviours among participants, encompassing physical behaviours (refraining from heroin use), emotional responses (resisting the temptation to buy and use heroin), and regulatory behaviours (restricting heroin use and its frequency). These are similar behaviours that are associated with recovery pathways and arguably, evince the values and conduct of people who do not use drugs but are "valued" members of society. The Scottish Government (2008) cite such behaviours as components of, and integral to, "good citizenship," a concept that, incidentally, underpins its definition of recovery and stands in contrast to negative stereotypes frequently associated with people who use heroin. To meet the challenges of rural living, Brian and Rhonda routinely plan their day, ensuring a consistent and accessible supply of heroin (reflecting consumer activities, as noted by Neale et al. 2007). They adeptly resolve fiscal, geographical, and chronological challenges thrown up by rural living while simultaneously balancing their daily heroin use. By consciously regulating their heroin consumption, they mitigate behaviours linked negatively to its use, such as "gouching", criminal activities, or public heroin use, actions that draw unwanted attention from community members and the police. They do, however, encounter risk factors often associated with heroin use, such as physical ill health, violence and overdose. Simultaneously, Brian and Rhonda consider themselves "part o' the community".

Brian and Rhonda are not angry or embittered about the hospital appointment; it was simply an addendum when they were explaining why Rhonda did not attend her GP. They did not problematise the considerable financial costs, money which could have easily and perhaps expectedly been spent on heroin. There was no complaint about the imposition of attending the appointment, despite potential safety concerns like physical assault, heroin overdose or withdrawal symptoms. Their experience and challenges reflect their everyday lives in a rural setting which they embrace and accept as part of their roles as rural actors. Reflecting on this, I did consider urban residents stoically spending 70% of their weekly income travelling to and from their local hospital and one-third of their day doing so, for a 5-minute consultation without complaint.

The conscious ability to regulate and control their heroin use prompts a reconsideration of the causal understanding of addiction. Brian and Rhonda's heroin use appears to be actively managed by them to specifically align with societal and cultural expectations, allowing them to maintain not only their presence within their community but also their ongoing integration into it. As Grund (1993) noted, the assurance of heroin availability diminishes the ritualisation of heroin, enabling people who use it to feel their use can be regulated. However, Brian emphasised their simple desire "to be left alane tae git oan wi oor lives." Despite Rhonda's acknowledgment that her heroin use has led to severe health issues, including overdose, near-death experiences, infirmity, a DVT, an inability to work and a constant fear of reprisals, preventing a return to her hometown, she continues to use heroin and does not want to change, even with access to free recovery and health services. Both Rhonda and Brian referred to themselves as "heroin addicts," I believe that's what they thought *I* wanted to hear. However, they do not self-identify as "addicts", and do not conform to the stereotypical image associated with the term "addiction". They do not aspire to or seek a drug-free life, despite self-regulation being positively associated with the transitional phase of the recovery pathway (Stallwitz and Shewan, 2012; Zinberg, 1984). They use recovery and health services to help navigate a complex relationship between themselves, their community, and their drug use, and strive to balance all three while continuing with their everyday lives.

Heroin use within Brian and Rhonda's immediate community is limited to six or seven individuals. However, alcohol and recreational drug use, which often led to violence, was described as "common" among the population of Kelloholm, according to Brian and Rhonda. The reasons for the limited prevalence of heroin within the community, despite its availability, remain unclear. Throughout my data collection, it became evident that the heroin subculture to which Brian and Rhonda belonged was too small to exert a widespread influence on the acceptance of substance-associated behaviours. Consequently, self-regulation played a crucial role in maintaining their conduct at a level acceptable to their community, allowing them to continue using heroin while remaining integral to their social fabric. This dynamic aligns with Goffman's (1963) observation which noted that a coterie who display deviant behaviours, such as heroin use tend to rationalise their behaviours within their immediate heroin-using circle while simultaneously regulating the use of heroin to minimise potential harm not only to themselves but others within the wider community of people who do not use heroin. Regulated heroin use and harm reduction were aspects commonly identified as recurring themes within my findings, facilitating the continued use of heroin. Notably, my findings did not reflect

evidence of a conscious or subconscious change toward a drug-free life, either through natural recovery or engagement with recovery services. Consequently, drug related deaths among people who use heroin were increasing within the region, reflecting the trend across Scotland, in 2018.

Brian and Rhonda's experiences are consistent with Stallwitz and Shewn's (2004) findings, which observed similar behaviours within the population of people who had heroin use experience in the Shetland Islands, Scotland. In their qualitative study, which employed in-depth interviews with 12 people who used heroin, they utilised Zinberg's (1984) "Drug, Set and Setting" framework to examine the impact of social and cultural factors on heroin use and associated behaviours in rural settings. Their study found their participants did not problematise their heroin use and reported self-regulation, although they did not delve into the rationales behind such behaviour. Brian and Rhonda's controlled drug use is devoid of any explicit reward other than what they consider a "normal life" within their community. It allows them to function within their environment, to be "normal" but it is not a conscious pathway to abstinence, a drug free life or transformation.

7.5 Chaos or order within rurality?

In this section, I consider whether "chaotic lifestyles" which are dominant within recovery discourse (Burhan et al. 2019; Darke et al. 2007; Dietze, et al. 2005; Strang, et al. 2016; Sun et al. 2016) impact people who use heroin within a rural setting. Dominant recovery discourse is supported by ethnographic studies (Bourgois, 1998; Bourgois and Schonberg, 2009; Briggs, 2012; Decorte, 2000; Harling, 2007; Shewan and Dalgarno, 2005; Siegel and Ramos, 2002) which, as we have seen, report heroin lifestyles to be consumed with income generation and the pursuit of consumer activities because "addiction" controls their lives. It is argued that the pursuit leads to chaos and chaotic lifestyles, ending in homelessness, poverty, physical and mental ill health and the exclusion of family and friends as well as disengagement with conventional societal norms.

I found during my data collection there was little evidence to identify or locate chaos amongst those who used heroin in rural Dumfries and Galloway. As exemplified by Brian and Rhonda's vignette, participant's lives and lifestyles were, in the main, ordered and conventional. Activities and behaviours relating to heroin and other drug use were generally, regulated, moderated and considered. They had to be to ensure inclusion within their communities of

people who did not report heroin use experience. People who used heroin were well integrated in their communities; their heroin use, although known about, was generally tolerated and not a cause for marginalisation or exclusion. However, those who used heroin in my study were not, overall, seeking to change to drug-free lives or to reduce their drug use, presenting an anomaly, and questioning whether chaos and abstinence should be reflected on an "addiction-recovery continuum", or situated in a different paradigm, if considered at all.

7.6 Locating chaos.

Chaos is characterised by disorder, confusion, and mess; it is arguably the nemesis of "drug addicts" in their journey towards recovery. Terms like "chaos" and "chaotic lifestyles" derive from a knowledge system influenced by its intellectual, political, and philosophical context and the manipulation and application of these by those empowered over those who are disempowered (Goffman, 1957; Foucault, 1994; Payne, 1997; Fraser and Moore, 2008). Chaos represents one end of a continuum that forms the chaos-order dichotomy in contemporary heroin narratives, deeply rooted and firmly fixed in modernity and persisting in neoliberal and neoclassical ideologies and society (Ambrose, 2014). Within this framework, values such as autonomy, rights, choice, and equality do not extend to "illicit" heroin use.

The labels of "chaos and chaotic" when applied to people who use heroin, as with addiction, lack universally accepted meanings or set criteria, despite their liberal application serving mostly as a pejorative term in discourse and studies. Fraser and Moore's (2008) framework introduce three independent factors to be applied in the application of chaos: people who use drugs as being chaotic, their drug-using lifestyle being chaotic, and their drug use itself as being chaotic. Ontologically, Foucault (1994) muses if it is possible to separate a person's life into autonomous parts, arguing chaos will permeate through all aspects of these parts. Consequently, chaos could not be confined to specific elements, activities or behaviours of the life of an individual who uses heroin, nor, however, could chaos be applied uniformly.

Serres (1995) drawing on work by Husserl and Deleuze, explains that chaos lacks a singular cause or source because human behaviour is not borne from unity, rather it arises from multiplicities. Rejecting the idea of unity and continuums, like chaos and order, which he sees as imbued with Western cultural values, Serres advocates for embracing the multiplicity inherent in chaos. He suggests that exploring chaos is not about categorising or resolving it, but rather a way to gain knowledge and understanding, acknowledging its diverse

manifestations within society. To this end, Fraser and Moore, (2008, p.743) contend not all people who use heroin are chaotic, but they suggest those who are, are more likely to face greater disadvantages and stigmatisation than those who are not. Despite conducting a meta-analysis using *Google* as their chosen database, their study does not elucidate the distinguishing factors that render one person who uses heroin chaotic while another is not, nor do they provide a framework to establish levels of chaos as a tangible measure. They write:

> "The meaning of "chaos" in these examples is left largely to the reader's interpretation, although some (confusing) clues are provided in the paradoxical linking of chaos with habit (and harm), but also in its juxtaposition with organisation".

The intricacies of what defines a chaotic heroin life, similarly to addiction remain elusive, but they were not apparent in Brian and Rhonda's life despite their habitual and chronic substance use. The Joseph Rowntree Foundation (2005, p.1) notes that data on chaotic lifestyles is typically gathered through self-reporting by people who have heroin use experience. A population, they observe, that often remains "largely hidden" aligning with the deviant and criminal elements linked to heroin and its use. On the first point it is noteworthy that people who use heroin themselves employ the terms "chaos and chaotic" and "addict" for self-identification, labels rejected by Brian and Rhonda. The origin of these self-identifying labels and the reasons behind their usage remain unclear. Davies (1993), in the "Myth of Addiction", posits that "drug users" apply "addiction terminology" to themselves and then subsequently conform to stereotypes associated with the terminology, reinforcing the social construct through self-fulfilment, perhaps as a means of acceptance by their peers.

It is crucial to acknowledge that service providers and recovery professionals also use these labels, evidenced for instance, in Rhonda's interaction with her new GP. Whether people who use heroin and service providers share a common understanding of their meaning and application of these labels remains uncertain, but it reflects Becker's (1963) concept of secondary deviance. The second point concerning this hidden population raises questions about how people who use heroin in a "chaotic" manner manage to remain hidden, even in densely populated areas where they are normally "invisible" and "ignored", chaotic drug use draws attention. It requires a leap of faith to assume that people who use heroin do so chaotically and in an uncontrolled manner, along with associated behaviours and activities, could remain hidden, especially in a rural setting, even among a naive populace.

Briggs (2004) study on “crack users” in London’s urban arena, highlights “crack use” and culture propels a cycle of street-level transactions, begging, minor criminality, reliance on social welfare, rough sleeping, involvement with the criminal justice system and imprisonment. In contrast my research highlights a tendency among my participants to exert agency in the regulation of their drug use, related activities and income generation. As Briggs found in his study my findings also reflect those participants exhibited an inherent cognitive aptitude and a clear capacity for logical and critical consideration of their lives and substance use. These disparities highlight the potential influences of urbanity in contrast to rurality on the inherent behaviours of drug use. Urbanity may play an inherent role in shaping the trajectories and structures of people who have “crack use” experience, their culture, wider social organisation and their environments. Social control mechanisms imposed on “crack use” by structural forces aligned with “crack use” identities and its urban nuanced management contrasts that of heroin use in rurality, despite discernible commonalities.

In rural areas, Gfroerer, et al. (2007), Mack, et al. (2017) and Schneider, et al. (2020) have all observed increasing patterns of drug use in their respective studies. Statistics from the Scottish Government (2018) corroborate these trends, estimating approximately 1,500 people who use heroin in Dumfries and Galloway. Within this figure, approximately 800 individuals are officially registered with SDAS, leaving an estimated 700 unregistered people who use heroin dispersed throughout the region. During my data collection, I encountered higher numbers than those estimates, with both participants like Mark (aged 40) asserting there are “fuckin’ loads mare” and SDAS members also suggesting a higher number of people engaged in heroin use within the region who remain unknown to services. Support worker John, however, notes a decline in heroin use, with an increase in other drug consumption. The substantial numbers of people who use heroin prompts the question of how people who use heroin manage to remain hidden in a close-knit community, especially if their heroin use is uncontrolled and chaotic, accompanied by its associated behaviours.

Existing literature suggests that sustaining chaotic heroin use in rural settings is not viable, given the constraints such as limited resources for income generation, a lack of anonymity, and the regular presence of law enforcement, all contributing to this impracticality. Conversely, my research findings indicate that people who use drugs in rural areas possess ample funds, have

access to low-cost heroin that is readily available, maintain inclusion within their communities, and exhibit an awareness of behaviours that might attract police attention.

Upon entering the field, I engaged in discussions with local healthcare professionals, including Gordon, an experienced SDAS nurse, to understand their interpretation and application of chaotic heroin use and lifestyles. Gordon "manages" a caseload of up to 50 people who use heroin. According to Gordon, a chaotic lifestyle involves, "No turning up fur appointments when they ken they should be here…they wur lettered weeks ago." "Did not attend" (DNA's) serves as an indicator of chaotic heroin use for Gordon. Several participants, however, expressed a lack of value in attending SDAS, citing other engagements as reasons for their non-attendance. Lynn, an experienced staff nurse told me, "They have chaotic lives…they are too disorganised to work." However, Lynn's understanding of a chaotic lifestyle, specifically the inability to work, did not align with my data. Many participants actively chose not to work, while others, like Brian, were employed but chose not to disclose employment information to authorities to avoid potential interference with their benefits.

Jenny, a senior staff nurse, explained, "Some of them can hardly function on a day-tae-day basis they ur sae chaotic." Of course, this may be what Jenny observes as her clients "perform" addiction for her. Again, Jenny's comprehension of "chaotic", not being able to function on a day-to-day basis was not borne out within my data, which revealed that people who use heroin not only functioned but often engaged in planning. On the contrary, Debbie, a senior staff nurse with over a decade of experience at SDAS, said (albeit glibly), "Some of the staff here [SDAS unit] are more chaotic and cause more chaos than any of the clients." Hughes (2007, p.680) exemplifies Debbie's perspective, as she extols the engagement and understanding of maintenance heroin use, self–regulation, budgeting, and forward planning, while rejecting the labels of "chaos" and "chaotic" as being components of the "addiction myth", portrayed and perpetuated in sections of literature, media and society. Hughes elucidates:

> "Chaotic use was described by our sample as episodic and spasmodic; associated with particularly "bad" times in peoples' lives where their engagement with non-users was described as "at a minimum". In effect, they had little or no family involvement, no home, they were not on benefits, had no formal job, did not access any healthcare services and did not mix with friends from non-using days".

My findings align with Hughes' study. Participants in my research possess social and recovery capital (family, friends, significant others), homes, financial benefits, and access to free healthcare and recovery services (including opiate substitutes). Some participants chose to work they had albeit irregular employment, but they still, as with most employees, had to meet the terms of the post. Engaging and maintaining these support systems would be arguably unsustainable if their lives were chaotic. For example, Brian and Rhonda reject the negative connotations of chaotic heroin use, its associated lifestyle, and an "addict identity," although they acknowledged being "dependent" on drugs and did refer to themselves as "addicts" on one occasion. An "addict" label and identity did, however, present opportunities which they seized upon to access recovery services, methadone, benefits and social acceptance. Controlled and regulated heroin use also brought positive consequences for them, reducing the potential for being cheated in heroin deals, potential violence, facing intolerance from their community, and, notably, attracting unwanted attention from the police. By presenting themselves in their community in a manner contrary to the public perception associated with drug addiction, Brian and Rhonda gained acceptance within their locale. This stance resonates with Radcliffe and Stevens' (2008, p.1065) assertion that "The junkie identity was generally seen as shameful and therefore to be avoided." However, the fact that they could and did occasionally choose to adopt an "addict identity" to access certain opportunities suggests that addiction is, arguably, a social construct and not an inherent, fixed condition, as posited by addiction concepts such as the medical or pharmaceutical models.

Within a rural setting, people who use heroin tend to adhere closely to what Bourgois (1998) termed the "moral economy," engaging in the sharing of heroin, new paraphernalia, money, accommodation, and behaviours. They form an interconnected, interdependent, and supportive community that mutually aids each other in their heroin use. As Harold articulated, "If a huv somethin', a share it an' if they (acquaintances) huv somethin', they share." My findings highlight a significant reliance on the "moral economy," ensuring continuous access to heroin and support when needed as I previously outlined when discussing Mauss's (1950) conceptualisation of "gift exchange." For example, Brian and Rhonda not only offer accommodation to Linsey but also provide food, companionship, and, of course, heroin. This interdependent relationship establishes a framework for potential reciprocal arrangements in the future, fostering a sense of contact and reliance on Linsey as well as an unspoken accord.

In contrast to Padykula and Conklin's (2010) study, which suggested that achieving and maintaining self-regulation is challenging for people who use heroin, my data did not consistently support this conclusion among participants. As observed, my findings do not indicate chaotic lifestyles, because chaotic lifestyles are counterproductive for participants. Participants emphasised that uncontrolled heroin use draws unwanted attention from the police and people who did not use drugs, potentially disrupting the heroin supply, a situation they strived to avoid. This aligns with observations by both Parkin (2013) and Briggs (2012), who noted that people who use drugs actively avoid "hazards" that could interfere with their drug use. Consequently, the application of the term "chaos" lacks a robust empirical basis in my study. Brian and Rhonda's home was well-kept and well-furnished, it was orderly, and they were orderly and well organised. This reflects their controlled and self-regulated approach to heroin use not only for specific events like hospital appointments but for their everyday lives. They were impeccable hosts and presented themselves as any conventional couple would, they committed to using heroin in a way that did not betray their "addiction" through its commonly associated behaviours and as Brian stated maintain their "normal life jist like everybody else".

7.7 Chapter conclusion.

To address my second objective, which aimed to investigate heroin use in the context of everyday life in a rural setting, I presented a vignette depicting an everyday occurrence that was initially overlooked due to its mundanity. The act of attending a hospital appointment for a routine scan revealed hidden, unconsidered, and unreported challenges faced by two individuals who report habitual heroin use. Through data analysis, I re-evaluated the prevailing discourse on the ability of people who report chronic and habitual heroin use to plan and self-regulate their heroin consumption to meet routine obligations such as a hospital appointment. Initially exploring the challenges posed by the appointment, I identified key aspects unique to rural living, such as travel, time management, and financial considerations. These key aspects prompted a deeper consideration of how the findings reflected the capacity of people who reported chronic and habitual heroin use to strategically plan and regulate their time and drug use, especially in the context of rural environments.

Recovery-focused literature often posits that controlled heroin use and self-regulation lie beyond the capacity of people who use heroin, as chaos is believed to inevitably follow and become associated with heroin use and addiction. This is simply the nature of addiction where concepts such as the medical model are applied. However, my exploration suggests that

dogmatic belief systems, predominantly shaped by people who do not use drugs or those who have overcome drug use, have positioned people who use heroin at one extreme end of a chaos-order continuum. Contrary to this narrative, participants in my study, such as Brian and Rhonda, demonstrated a significant ability to make nuanced judgments, rejecting the prevailing chaos narrative, and "performing" addiction when required. Self-regulation was generated as a common theme in my data, consciously employed to facilitate the integration of those who use heroin into their communities and to navigate everyday challenges typical of people who do not use drugs within their rural surroundings. This, however, sits juxtaposed to addiction concepts that espouse narratives that addiction is beyond the control of the individual. Notably, this occurred in the absence of active recovery support and networks which Brian and Rhonda rejected, apart from a low-dose methadone program, because it was free. Despite the positive indications of self-regulation in recovery and the acknowledged impediment of chaos to it, there was no evidence in my study that rural people who use heroin actively wanted to change and pursue a drug-free life.

Bringing the works' "car" home. Autumn 2018.

Chapter 8: Exploring the meaning of recovery for people who use heroin in Dumfries and Galloway.

8.1 Introduction.

In this final findings chapter, I address my third objective, which was to explore what meaning recovery has to people who use heroin in Dumfries and Galloway. I aim to uncover whether the concept of "recovery" is interconnected, shared or recognisable within a rural context among people who use heroin. I seek to locate the Scottish "recovery strategy" within an active community of people who use heroin in rural Dumfries and Galloway. I explore how definitions and understandings of recovery are perceived and interpreted focussing on three key participants and by SDAS staff tasked with implementing recovery initiatives. I aim to identify any dominant shared factors from *The Road to Recovery* (2008) strategy that guides SDAS staff in their professional roles. Through this investigation, I seek to determine if recovery values are shared, embraced, and have an impact on people who use heroin within a rural setting.

I argue that recovery is not a straightforward, universally understood concept or a linear change from problem drug use to abstinence, punctuated by recovery-focused interventions and treatments such as methadone. Rather, there exists a multitude of influences, perspectives and outcomes related to everyday rural heroin use, with neither transformation nor abstinence prominently or dominantly emphasised by those responsible for implementing the strategy or by people who engage with heroin use to whom it is directed. Recovery in essence reflects a process of dynamic change, characterised by idiosyncrasies of those people who use heroin reflecting their specific needs and environment. My findings illuminate aspects of recovery unique to rural settings, expanding upon my previous chapters, but they do not fully explain the phenomenon of multiple recovery indicators, where heroin use persists, where transformation and abstinence are roundly and consistently rejected. These findings prompt the question: why do people who use heroin within a rural setting not embrace abstinence as advocated by "*The Road to Recovery*" strategy?

8.2 Locating people who use heroin in rural areas within the context of Scotland's drug policy.

I begin this chapter by revisiting Scotland's first autonomous drug strategy, "*The Road to Recovery"* (2008), which outlines the Scottish Government's strategy for achieving recovery

(reducing harm and abstinence) from drug use. Working within the parameters of the UK's Misuse of Drugs Act (1971), the Scottish Government aimed to overhaul the incumbent harm reduction strategy, integrating abstinence into the recovery pathway for the first time. This strategic shift aimed to accomplish broader societal goals to, "Get more people back to work; revitalise some of our most deprived communities; and allow significant public investment to be redirected" (Scottish Government, 2018, p.IV). The Scottish Government (2018, p.1), stated:

> "Our national drugs strategy focuses on recovery but also looks at prevention, treatment and rehabilitation, education, enforcement, and protection of children. Too many people are ruining their own lives and harming others around them through the use of drugs."

The Scottish Government's definition of recovery is clear and unambiguous, and states recovery is where:

> **"**An individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society" (Scottish Government, 2018, pVI)**.**

With these clear objectives, society expects governmental strategies to achieve and fulfil their goals and deliver on manifesto pledges (Ball, 1993; Blackman, 2004; McKeganey, 2011). As with all Scottish policymaking, *The Road to Recovery* strategy was initially developed centrally and then cascaded and disseminated to the fourteen regional Scottish health authorities. These health authorities (Health Boards) are responsible for implementing and executing the strategy through institutional structures such as the Dumfries and Galloway NHS SDAS. However, as Lipsky (1969) pointed out, "street-level bureaucrats" such as professionals within SDAS can significantly influence how policies are implemented, thereby impacting the lives of people who use heroin.

As evident from the Scottish Government's *The Road to Recovery* document, drug use is characterised as problematic, with people who use drugs perceived as posing a danger to themselves and others due to the associated harm caused by drugs. The strategy depicts people who use drugs as inactive, non-contributing members of society, unemployed or unemployable,

and residing not only in deprived areas but in the "most" deprived and impoverished regions, while presenting a financial burden on public resources. The Scottish Government's approach did not differentiate between types of drug use or people who use drugs; rather, it amalgamated them and assumed all drug use to be problematic, with an expectation that all people who use drugs wish to cease their use, a premise I held when I entered the field. Best et al. (2011) also acknowledge that these factors, whether considered in isolation or combination, should serve as motivation for people who use heroin to actively seek and engage in change, striving to achieve and sustain abstinence proactively and consensually. The strategy of the SDAS aligns with this perspective and underpins the significance of treatment in achieving this objective, as articulated in its unit philosophy (2018, p.1), which states:

> "The Specialist Service adopts an evidence-based approach to treating drug and alcohol problems and views treatment as a key part of the Recovery Pathway".

Assumptions drawn from such statements and recovery literature could arguably lead one to expect that rural people who use heroin would willingly and actively seek out "free to use" recovery and health services such as the SDAS, seeking support to initiate change and attain abstinence. It could also be anticipated that the SDAS, equipped with varied modes of treatment and interventions would facilitate their request. My findings confirm that the SDAS unit was well-resourced and staffed by trained healthcare professionals. Based on these premises, I initially expected an efficient, well-attended, and effective service that assists individuals with addiction issues to actively engage with recovery strategies and treatments, ultimately seeking and achieving abstinence promptly, efficiently and effectively.

Lipsky (1969, p.2) also suggests that although not of "primary importance" street-level bureaucrats often serve a "non-voluntary clientele group". This factor became significant to my study participants and one that was consistently evident in the data. For many, attending SDAS was non-voluntary, and participants frequently expressed reluctance to interact with "street-level bureaucrats." Nonetheless, they felt compelled to do so fulfilling an obligation and performing their part to access and attain services and resources (such as free needles, syringes, and methadone) that facilitated drug use. However, this does not fully explain their "non-voluntary" status or their reluctance to engage with free, accessible, and professional services aimed at assisting them in achieving a drug-free life. In the following section, I outline the recovery perspectives of three key informants who represent varying levels of drug use,

duration, and age, providing a comprehensive representation of my participant group, all of whom have interacted with SDAS over many years.

8.3 Exploring recovery in rural settings: The everyday recovery of people who use heroin.

I spent considerable time with these three key informants during my fieldwork, aiming to gain a candid understanding of what recovery meant to them. Their perspectives offer valuable insights into their lived realities. Together, they possessed over 70 years of experience with heroin use and were all long-term residents of the region.

8.3.1 Mike.

I arrived to meet Mike at 9.30am and I heard music emanating from his open windows as I walked through the housing scheme to his home. Mike, oblivious to the cold, welcomed me into his home, he is barefoot and dressed only in a t-shirt and jogging pants despite the chilly March weather. Mike's home, a local authority single-bedroomed mid-terraced bungalow, is known locally as a "pensioner's hoose" due to its typical residents being older single adults aged over 65. Situated on the peripheries of a fishing village in a small local authority housing scheme, Mike's home appeared sparsely furnished, and a little untidy. The windows were wide open, allowing the unmistakable acrid smell of heroin and cannabis, which I have become adept at recognising, to escape.

Standing in his small, cold yet sun-soaked living room, I gaze beyond the adjoining bedroom through its curtain-free window, overlooking a bay. In the cold of an early spring morning, the sunlight reflected off the still water, only occasionally disturbed by waterfowl gracefully gliding to a halt over its glassy surface. Though somewhat clichéd, the scene fills me with wonder, it's truly breathtaking. "Am goin' in tae toon tae get ma new script….ur yi passin' the chemist?" 32-year-old Mike, who has used heroin intravenously for 15 years, breaks my reverie. He is uninspired by the view, which he has long grown accustomed to. Mike is tall, of medium build, with a shock of blonde hair, a fresh youthful hue, a bright outlook on life, and an unmistakable twinkle in his piercing blue eyes. A lifelong resident of the village, he has no intent to leave. Mike's company is "easy". He was personable, charismatic, good-humoured and an engaging storyteller. He laughs a lot and patiently answers my questions, taking the time to explain himself and the points he makes. Quick-witted, he often answered my questions with questions of his own, slipping effortlessly into the researcher role himself.

Like so many other participants, Mike does not fit the stereotypical image of a habitual and chronic "heroin user" commonly depicted in literature discussed in my earlier chapters. Studies by researchers such as Bourgeois (1992), Boyd (2002), and Johnson et al. (1999) portray heroin "addicts" as physically and mentally unwell, homeless, dirty, dishevelled, and displaying the signs and ravages of chronic “heroin addiction”. In contrast, Mike, unlike Lindesmith's (1968) participants who identified as "addicts", refused to identify as such, instead likening himself to people in his community who do not use illicit drugs. He expressed puzzlement at this notion, stating that he is "jist the same as everybody else", a sentiment echoed by many participants, who considered themselves "normal." Mike placed himself as an integral part of his broader community, actively participating in everyday practices alongside his peers, reflecting his acceptance by other people who engaged with him and accepted his lifestyle without judgment, illustrating his integration within his community.

Mike had never been employed. He lived alone and was single, but he possessed recovery and social capital receiving a monthly income of over £900, from Employment and Support Allowance (ESA) and Personal Independence Payment (PIP), supplemented by housing benefits that paid his rent, and exemption from council tax. Like many other participants, Mike relied heavily on support from his family. His mother, who worked full-time as a school dinner person, “helped” him with cooking, cleaning, and provided emotional and financial support. Although Mike never met his biological father and did not discuss him, he had a wide circle of friends. However, Mike complained:

> “There’s fuck aw tae dae here…..a cannae git a job, cannae git a burd, cannae move, ivery cunt kens aes and whit a dae.”

Being unemployed, on a low income, impoverished, from a single parent family, and without a partner, places Mike firmly within the parameter set out by the Scottish Government for people who were likely to be affected by “addiction”. He possesses and demonstrates clear characteristics as to why he *should* change his lifestyle and drug using career and consequently engage with recovery. He had access to free recovery capital; health and addiction services, strong family support, and a home. Mike, however, does not problematise his drug use or his lifestyle, he showed no desire or motivation to change his life, he was content living his best available life.

This became clear as we spent time together and conversed. Mike's "negative" situation was not congruent with his outwardly positive demeanour and the way he portrayed his life; he appeared physically, emotionally and mentally well. His "monotone" description of his situation, of how *he* wanted me to perceive his life appeared well-rehearsed, a phenomenon I observed consistently among participants during initial meetings or when SDAS workers were present. Participants often felt compelled to "perform" their "addict identities" to play their part in an "addiction" performance to ensure they received drug related resources. As time passed, Mike visibly relaxed in my presence. With a smile, he explained that employment opportunities were available to him, and that he could "easily" obtain employment but, as he and other participants indicated, employment would reduce or stop his benefits and place demands on his time. According to Mike, his potential earnings within the village would not surpass what he received from state benefits; he would be in a worse financial position. Further, unemployment made Mike time rich, time he used to pursue his preferred activities. With state benefits meeting his needs and his status as an "addict" securing his situation, Mike felt no urgency to pursue income-generating activities or recovery pathways. At times of financial hardship, as many children do, he simply turned to his mother for assistance, saying, "A tap ma Ma fur twinty quid."

Once a keen runner and talented soccer player in his youth, Mike's everyday now comprises of "playin' computer games, watchin' telly, hinging oot with ma mates, n' takin' drugs." He believed that maintaining a long-term relationship or employment would disrupt his routine, although he did engage in casual relationships. Despite his lifestyle, he maintained a close relationship with his mother, regularly visiting her for food, laundry services, and company. Although his mother disapproved of his drug use, "especially ma smokin" they remained close. Beside drugs, Mike spent his weekly income of £230 on: "Chinkies*, [Chinese takeaways] sweeties, choaclit an' proper fags.**" [1]Despite drugs being readily available, Mike, like Brian, Rhonda, and other participants, demonstrated an ability to control and regulate his heroin use, a practise also observed in studies by Zinberg (1984), Decorte (2000), and Warburton et al. (2005).

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[1] * In this context, the term "Chinkies" is historical colloquialism referring to takeaway food of Asian origin. It was not intended as a racial slur but is recognised as passive racism and a long-outdated term.

**Proper "fags," related to factory-manufactured cigarettes, a "luxury item" usually substituted for less expensive loose tobacco and roll-up papers often used by people who use heroin within rural Dumfries and Galloway.

Mike never discussed his drug use or expenditure until I asked directly; again, he smiled and explained that he used drugs when he felt the need, which in Mike's case, turned out to be every day. He estimated that he spent between £10 and £30 per day on heroin and cannabis, purchased from "a mate in the toon." Despite his regular drug use, Mike fell into the category of a level 1 person who uses drugs (refer to Table 1 in Chapter 6); he did not sell drugs, he "share(d) drugs with friends." While he did not reveal the identity of his drug supplier, he remained unperturbed when asked (in my naive attempt to gather other participants through "snowball sampling") if he would pass on my contact details to them. Mike explained that while his own substance use history was well known within his community, he felt the need to safeguard the identities of other people who use and sell heroin to avoid being labelled a "grass," potentially jeopardising his safety and access to heroin.

In rural Dumfries and Galloway, where community ties are strong, I found the connections between people who use drugs and those who sell them to be deeply entrenched. These relationships are mostly built on longstanding friendships or family connections, and the more rural the environment, the stronger and longer standing the bonds were, paradoxically those relationships presented significant obstacles to change. Geographical relocation away from their social networks is impossible if the person wishes to remain within the region, which firmly tethers individuals to heroin and its associated lifestyle. This dynamic recurred throughout my study, consistently impeding recovery pathways, personal transformation and efforts to change drug use.

I unwittingly met Mike's drug supplier in the village when he agreed to participate in my study. In line with other people who sold drugs locally, he mentioned that there was a high demand for his product, stating that he "can't keep up wi' demand", contrasting Lenardson et al.'s (2016) findings that found heroin was challenging to obtain in rural areas. He then went on, albeit inadvertently, to identify his customers by describing them and the area of the village where they lived, "there's one in t' bungalow o'er there" pointing in Mike's direction. I recognised Mike and several other participants from his descriptions, highlighting the lack of anonymity. This lack of anonymity within the community could have potentially compromised relationships between those who use drugs and those who do not, influencing and hindering employment opportunities for instance, which Hennessy (2017) considers crucial for recovery. This surprisingly, was not the case.

Mike's daily routine, typical of many people who use heroin in rural Dumfries and Galloway, started with a morning visit to his pharmacist for his daily dispensed dose of 30ml of methadone. Mike's pharmacist knew him well; he was friendly, engaging and respectful. Mike explained they would notify SDAS if he missed his script. In turn SDAS, would then contact Mike (or his mother) to make sure he was "well" (i.e., alive). Mike welcomed this intervention stating, "They [the pharmacists] keep an eye oot fur me." Mike engaged with people in his neighbourhood exchanging "banter", as he made his way to his friends' houses at the other side of the "scheme", where they hung out until the late afternoon and Mike would often visit his mother before stopping at his local pub on his way home in the evening.

Mike's 30mls of methadone was low compared to the usual daily dose of 60-120mls (BNF, 2021). It aligned with Strang, et al.'s (2005) study on methadone dosage by general practitioners in England and Wales (where heroin purity is reportedly higher) which found 50% of prescriptions for methadone were also 30ml. van Ameijdan et al. (1999) reported the effectiveness of lower doses in lowering drug-related mortality. Mike had his intentionally kept low to reduce the risk of drug overdose and death because of his associated heroin and other illicit drug use, along with prescription drug and alcohol use, a trend becoming consistent among participants in my study. Walcher et al. (2016), however, suggested that inadequate methadone dosing can lead to increased dropout rates from "treatment". This was not observed among participants in my study, who primarily sought methadone because it was free. While many expressed a desire for a higher dose, they mostly compromised and accepted a "maintenance" dose. Quite what a "maintenance" dose was remained unclear but erred towards stabilising the individual's drug use and life.

Mike was unperturbed by the dose or a lack of privacy during the dispensing process for his methadone, which was issued in public view due to the pharmacist's lack of a privacy booth and the shops open window frontage. He received a "seen" script every morning except Sunday when the pharmacy was closed. On Saturdays, he received a double dose, which he, similarly to every participant, consumed later the same day taking extra drugs on Sunday to compensate. Mike did not problematise this situation stating, "a dinnae care."

Mike as with other participants, reported that he did not seek methadone for its "hit," or to titrate his heroin down, it was not part of his recovery strategy. He wanted methadone because,

as with all healthcare provisions in Scotland, “it’s free”. Mike also explained that methadone alleviates any potential withdrawal symptoms, but essentially because it can be quickly increased by the SDAS should heroin ever become “difficult tae score” although this had never been the case since he started using it. Mike, however, explained the lengthy process of self-referral or referral by a general practitioner to SDAS could be avoided if somewhat paradoxically, he continued with his methadone. New referrals, including previous SDAS patients, faced an “assessment period” of up to eight-weeks before potentially receiving a methadone prescription. The time required to register (or re-register) with services is negatively indicated in positive recovery outcomes and “is often listed among the most common barriers for those seeking treatment” (Redko, et al. 2006, p.831).

Neale’s (1998) study on methadone use in urban Glasgow presents a contrast to Mike’s motivations for using methadone. Neale identified positive health effects and reduced illicit drug use among her study’s participants (n80). Similarly, Gryczynski, et al.’s (2009) study on 183 people who used methadone in urban U.S. indicated “treatment readiness, problem recognition, and a desire for help” as reasons for their participants’ willingness to engage in a methadone programme. Aspects not reflected in my findings. Mike explained that he did not rely on methadone because he had “nae problem” sourcing heroin, a sentiment cited by other participants in the region. He explained that he purchased heroin daily to use with his friends, because he “will yase it if it’s there…wi ma mates” illustrating a form of self-regulation in his drug use. While Mike exercised control over his heroin consumption, he also recognised that he could not self-regulate in the sense of refraining from using or sharing drugs if they were physically available. This pattern of self-regulation was reflected by other participants in my study and aligned with Hughes (2007) research on controlled heroin use in England in environments where stable drug supplies were assured.

Participants in the region were typically prescribed lower doses of “maintenance” methadone because they concurrently used heroin, with no participant (nor any known to them) exclusively using methadone. SDAS staff showed little concern about ongoing and concurrent methadone and illicit drug use, as a prescription ensured ongoing contact with their clientele. Setting methadone dosages often led to disputes between SDAS nurses and participants, resulting in ongoing tensions in their relationship. Participants frequently requested higher dosages of methadone, claiming it helped reduce or maintain their current level of illicit drug use, a point not supported by my findings. This is when “performances” were often noted, with participants

exaggerating or feigning withdrawal symptoms to increase the likelihood of higher dosages of methadone or prescription benzodiazepines. No participant expressed a desire to titrate their methadone to stop their heroin use. Some mentioned they briefly attempted to reduce their heroin intake so they could increase their methadone prescriptions but quickly returned to their original methadone dosage upon failing to sustain their reduction in heroin use.

SDAS staff, in contrast, explained that they issued daily scripts and prescribed the minimum dose of methadone, using a straightforward titration formula to calculate methadone amounts; higher heroin and illicit drug use (identified from blood or urine tests), equated to lower methadone prescriptions, to ensure:

a) Daily contact between people who use heroin and services to ensure they were alive.
b) Prescriptions were stopped when individuals did not attend for their methadone for three consecutive days, signalling potential unregulated drug use or even death. To recommence their methadone script, the person had to visit the SDAS in person, provide a urine sample for heroin screening, and have their methadone titrated accordingly.
c) Reduced risk of overdose and death.
d) Prevention of the onward sale of methadone.

While SDAS considered these "procedures" part of their "recovery pathway" and "treatment planning", individuals like Mike, with a substance use disorder, regarded them as, "Fuckin' shit." The SDAS process, however, ensures regular contact between those people who use heroin and SDAS, albeit vicariously at times through pharmacists, with contact being considered crucial by SDAS to reduce increasing drug-related deaths.

Before commencing my study, I had assumed the concurrent use of methadone and heroin would be a "transient" arrangement, aligning with the principles outlined in *The Road to Recovery*, and, as White and Mojer-Torres, (2010) identified, that methadone would increase as heroin use declined until it stopped, then there would follow a steady reduction in methadone until it too stopped, and abstinence was realised. Schuckit, (2016) wrote that by using a reducing methadone prescription, abstinence from both heroin and methadone could be achieved within one to two weeks, without withdrawal symptoms. A surprisingly speedy yet safe means to achieve *The Road to Recovery* strategy goal of abstinence. However, this envisioned trajectory never materialised among my participants in my study. They did not discuss reducing or discontinuing methadone or heroin use, nor did SDAS staff indicate any need or give any encouragement or provision of a timeline toward abstinence. Participants

routinely reported prolonged use of methadone but little, if any, benefit from it. Regardless, they took it anyway, attending SDAS regularly to ensure continuation of their prescription. There were no formal requirements set by the SDAS for people who used heroin to engage in recovery-focussed interventions such as counselling, group work or therapy, nor were there any conditions attached to obtaining methadone apart for a positive heroin screen. These interventions, however, as White, (2004, p.2) reported have been shown to positively sustain change, with "92% of people who use heroin who achieve sustained recovery do so after participating in treatment." In my study, participants showed no change in their heroin use when using methadone, nor did they view methadone as a vehicle to reduce their heroin intake or achieve a drug-free life.

Mike's "treatment" for his substance use disorder consisted of methadone and his methadone prescription was scheduled to increase to 40mls. He had agreed to discontinue his Co-Codamol (30/500), an opiate-based prescription analgesic, which Mike seldom took because he "Cannae be arsed goin' tae ma doacters tae git the script" and does not like "swallowin' tablets." Instead, he gave his Co-Codamol, which his mother had acquired, to friends for free, a fact he did not disclose to his SDAS keyworker. Mike had been prescribed Co-Codamol following surgery to his face and head due to a "fall" down several concrete stairs while "Muckin' aboot wi' some pals…I wis oaf ma tits like." His key worker explained that Mike's injury was severe and life-threatening, primarily caused by excessive alcohol use, and not illicit drugs consumption.

Mike was "fuckin' chuffed" that he is getting extra methadone, emphasising he had not lied to attain more, which seemed a crucial point for Mike to assert to me. Mike only accepted the proposition after telling his keyworker he no longer wanted to continue with his Co-Codamol tablets (because his mother "nagged" him to get it). It was she who offered to increase his methadone to offset potential withdrawal effects and any consequent increase in Mike's heroin use. Mike was delighted with this proposition, but to my mind made his recovery pathway unclear and ambiguous. I broached this by asking him about recovery directly. He explained in detail his physical and mental health issues, stating, "I have schizophrenia, maistly positive signs, and I suffer panic attacks, I get olanzapine and benzodiazepines….I fractured ma left zygomatic, maxilla and temporal bone in ma heid when I fell. A get Co-Codamol for that but it's shite and I dinnae really bother wi' the olanzapine". Mike's response is "rote," employing complex yet appropriate medical terminology that clearly contrasted his normal vocabulary. Mike related recovery to his physical and mental health, not his drug use.

When asked about recovery specifically related to his drug use i.e., reducing his heroin use, becoming abstinence, and leading a “non-deviant” conventional lifestyle, Mike looked puzzled and stated, "A dinnae really ‘hink past peyday tae be honest." He was candid about not altering his drug use or lifestyle and saw no issue with his identity. Methadone, he confirmed, was not taken with the aim of discontinuing heroin use; he had no intention of reducing it and no plans to commit to a drug-free life. However, he made it clear that if methadone were not made available from SDAS, he, like other participants had, “Nae reason tae gaun.” Within his peer group, Mike mused that he did not know anyone who had "recovered" (interpreted as abstinence) or who wanted a drug-free life. Mike, like other participants, had briefly stopped using heroin—for "3 or 4 days, tae see if I could." However, he resumed heroin use because he "missed it," "likes it," and felt "bored" without it. During that hiatus, he continued using methadone and other drugs. Mike’s reasons for using heroin aligned with those in Best, et al.’s (2011) study, which examined 109 “heroin users” in London: pleasure, availability and to alleviate potential withdrawal symptoms were found to be the key reasons for its use. Mike was not being obtuse or evasive about drug recovery; he was clear he did not view his drug use as problematic and had no desire or intention to stop using heroin, stating, “A dinnae want tae stoap……why wid a?”

Mike likes his life, his lifestyle, and heroin; at 32 years old, he was among the youngest individuals I encountered. Comparing him with other participants it was evident, as previously mentioned, that he shares a common background with them: impoverished, unemployed, and in many ways “vulnerable,” due to his lifestyle. Mike's vulnerability, however, extends not only to the risk of overdose and associated health issues typically associated with illicit heroin use but also to his sensitive and caring nature, leaving him exposed to potential exploitation or manipulation. Nonetheless, in line with the findings of Thalbourne and Houran (2004), who explored the relationship between happiness and substance use, Mike is not "unhappy” he leads a full, happy and largely conventional life despite his heroin use. He had his own house, a regular income and a strong support network comprising of friends, family, and wider community. These characteristics align with traits commonly associated with people who do not use heroin (Scottish Government, 2018; Allen, 2008; Davies, 1996; Szasz, 1975) and are often linked to recovery capital, unspoiled identities and “normal” everyday life. Mike as with many of my participants, does not fit a stereotypical portrayal of people who use heroin for instance, depicted by Richardson (2018) or Vosburg (2016); as undesirable, ambivalent, or

self-absorbed liars. Mike, as Inciardi (1979) found in his study on heroin use and criminality in the U.S., does not perceive himself as deviant or criminal for using heroin. He rejects the label of "spoiled" despite his heroin use, although he acknowledges his substance use disorder and the associated risks of using illicit drugs evidenced by his injury. According to Mike, he does not engage in theft or bother anyone, and he enjoys a level of respect from members of his community, as a result the police, “Leave us alane….maist ae the time [laughs].”

Mike became restless as the morning wore on; his new prescription was not due to be ready until after 11am (prescriptions are sent directly by the SDAS to the pharmacy to prevent tampering). At 10.55am, Mike readies himself (puts his shoes on) and I drop him off in, what Mike identifies as, my “shit car” at the only pharmacy in the village at 10.59 am. Upon arrival, he bids me a brief farewell, promising to meet again "soon," without specifying a time or date. He was warmly greeted by an elderly gentleman passing by on the street and then by his pharmacist as he entered the shop.

In summary, Mike's everyday practices are intertwined with negative aspects commonly associated with heroin use, including a spoiled (drug using) identity, involvement in criminal activity (purchasing and using class A drugs), unemployment, a broken home and impoverishment (McIntosh and McKeganey, 2000; 2002; Watson and Parke, 2011). His drug-taking behaviours are widely known within the small village where he resides, a fact reinforced by his regular visits to the pharmacy for methadone. I had expected such factors to serve as significant motivators for individuals like Mike to actively engage with the recovery pathways and pursue change.

Mike, however, defied the conventional “drug using” stereotype, he did not problematise his heroin use or lifestyle, and he was generally happy and content with his life, articulately explaining he had “nothing to recover from.” Many of the typical harm indicators commonly associated with drug use were not only normalised but some, such as unemployment, were regarded positively by Mike. He consciously declined employment opportunities and relationship commitments because they did not align with his preferred way of life not because of his heroin use. Despite being aware of his lifestyle, those people who did not use drugs in his close-knit community did not ostracise Mike, and he did not face marginalisation often associated with people who use heroin. While Mike maintained regular contact with recovery services, his engagement and “addict” identity and subsequent role he portrayed was solely to

access methadone and benefits while recovery services used these as levers to engage with him, neither he nor the services prioritised changing his drug use through reducing or abstaining from methadone or illicit drugs.

Recovery and social capital played significant roles in Mike's life, arguably helping to stabilise his drug use and lifestyle. However, "negative recovery capital" was also prominent, playing an equally significant role in sustaining his drug use. Similar to other participants, Mike regulated his heroin use without resorting to "income-generating activities" typically associated with people who use heroin, such as theft or dealing, (Maher, et al. 2002, p.X), primarily because he did not need to. This aligns with an assertion by Warburton et al. (2005) "that heroin use only becomes a problem once it began to intrude into their (people who use drugs) everyday lives." Despite his heroin use, Mike's everyday life was largely conventional and often characterised by happiness and fulfilment, a perspective not commonly highlighted in literature on "drug addiction". This observation supports Nettleton, et al.'s (2012, p.176) assertion that there is insufficient attention paid to the "desires and aspirations" of people who use heroin.

8.3.2 Deek.

In the following section, I introduce "Deek," a 48-year-old individual who has been using heroin for approximately 30 years and served as a key informant. Deek falls into the category of a level 2 person who both used and sold drugs (refer to table 1 in chapter 6). Due to the long-term damage sustained by regular intravenous heroin use, Deek has predominantly shifted to routinely smoking heroin, although finding a vein remains a challenge, it is "not impossible." Despite his decades-long habitual heroin use, Deek, like Mike, maintains good physical health and expresses that he is happy and content with his life, a recurring theme observed among participants throughout my study. Deek indicated from the outset that he had no intentions of changing his lifestyle or drug use, but he had told his key worker that he did want to stop his methadone. I sought to delve into his motivations behind his decision and explore whether this change marked a step on his recovery pathway to address his drug use by transitioning away from heroin use toward abstinence as outlined by *The Road to Recovery* strategy.

Deek lived in a small second-floor local authority flat in a housing scheme in Dumfries. He reported having lived happily in this area throughout his life and had no intentions to relocate. Despite living alone Deek had a wide network of family and friends. He was unemployed and

relied on £960 in monthly benefits which Deek was "happy with" because it covered all his expenses. His flat, paid for by benefits, was well furnished, clean, and always nicely presented. Notably, Deek was always immaculate, impeccably dressed, clean-shaven and wearing cologne. He invited me to accompany him on his customary morning trip to his pharmacy at 9am (prompt) to collect his "seen script" of 45mls of methadone. As we walked the mile-long route from his flat to the pharmacy our conversation centred on recovery and what "meaning" it held for Deek:

> "Fuck, tae be honest, aye, a like ma life…. [He smiles]. A want tae git oaff the 'done though, but it's hard even when its doon tae like 5 or 2ml, ye still rattle fur four week, cannae settle, cannae sleep, git sick, know?"

Deek was referring to a gradual 2 or 5ml weekly reduction in his methadone script. Opting for a reduction of 5mls per week would take him nine weeks to stop his methadone. However, Deek expressed a preference for a more gradual reduction of 2ml per month, which would take 30 months to reach a zero dosage. Importantly, Deek explained he had not "seriously" broached his methadone reduction with SDAS and he was clear that his intent never involved stopping his heroin use. Nevertheless, Deek stated he wanted to stop his methadone a medication he had been on continuously for twenty-five years, which he had never reduced before. The reason?

> "Fuckin' inconvenience!…..SDAS every month, trail tae the chemist [pharmacist] every day, yi git fuck aw fae it [no effect] an' a dinnae want tae be auld an' still oan it."

Deek's motivation for discontinuing methadone stems primarily from inconvenience rather than the prospect of engaging in detoxification or pursuing abstinence. It was fear of withdrawals symptoms that prompted him to opt for an extended reduction period. Deek's perspective on methadone usage aligns with those of other participants in my study, but contrasts with Stone and Fletcher's (2003, p.45) findings, who noted "Users understand the need for daily supervision of methadone and are generally willing to accept it." Such compliance was not observed among the people who used heroin in my study, all of whom wanted weekly scripts.

Participants expressed frustration with the requirement for daily scripts, viewing it as bureaucratic, coercive and unnecessary. Their preference for weekly scripts was a recurring

and common theme among my participants which was routinely rejected by SDAS staff. In addition to his methadone use, Deek did not change his drug use habits, which included illicit benzodiazepines, pregabalin, and alcohol. He had no intention of seeking or wanting employment and he liked to keep relationships "casual like" to avoid commitment and the need to "explain his actions." Deek candidly expressed his disdain for the current SDAS system, stating that having daily scripts was, "Fuckin' degrading for a 48-year-auld man tae go cap in hand tae these bastards (SDAS staff)."

My analysis revealed that the requirement to collect daily methadone scripts had both positive and negative implications for participants. From a societal perspective, it served as a form of harm reduction, providing regular contact with pharmacists who could relay concerns to SDAS for intervention, if necessary, while also helping to regulate heroin use through dosage adjustments of methadone based on detected heroin levels. However, participants often felt a loss of confidentiality and experienced feelings of indignity and embarrassment when collecting daily scripts, with some expressing a willingness to disengage with ("stoap using") SDAS as a result.

Rozanova et al. (2017) warns of the risk of overdose in the absence of methadone, which leads individuals to increase their illicit drug use to compensate, a trend observed in my data. Deek acknowledged taking both Saturday and Sunday doses of methadone together, a practice SDAS are "aware" of despite its policy implications. Deek stated that "A always huv….everybody does, and Cameron Hoose (SDAS) ken it as well." This behaviour as Rozanova, et al.'s (2017) study found, often led to increased illicit drug use on Sundays to counteract potential withdrawal effects, despite Deek's assertion that he derived no benefit from methadone. Although Deek discussed discontinuing methadone with me, he had not taken steps to do so with SDAS, despite the "inconvenience" that he cited it caused him every morning. So why take methadone? Deek is clear; it ensured he did not experience the "Fuckin' hell ae withdrawin'….and it's free". This is despite, as with my other participants, never having been without heroin he identified the possibility as a risk not worth taking.

We arrived at the rear of the pharmacist avoiding the main entrance on the street and went through an unmarked door entering a small, windowless and empty room. Deek knocked twice on a small hatch, which was briefly retracted, revealing a pair of eyes that acknowledged Deek before fixing on me, "wi me" Deek stated, and the hatch closed abruptly. Reopening, a

disembodied hand passed Deek his green methadone in a small dosage cup. After drinking it he flushed the cup with water and drank that. Deek then disposed of the cup in the waste bin, and we left, nothing was said. This experience was quite a contrast to Mike's encounter at his pharmacy. Deek remained on the same dosage of methadone, heroin and other illicit drugs and continued his engagement with the SDAS and his pharmacist solely to obtain methadone. He never participated in any recovery-orientated interventions or any other treatments other than to provide an obligatory urine sample "a huv tae pish in a wee bottle every fuckin' twa week" for testing". As with Mike, SDAS did not exert pressure on Deek to pursue alternative forms of treatment or abstinence. However, Deek used his "addict" diagnosis to access benefits and recovery resources from SDAS, emphasising and accentuating symptoms to ensure their continuation. Deek filled his days pursuing leisure activities such as playing snooker with friends, housekeeping, reading, and watching television. Deek, like so many of my studies participants, did not problematise his drug use:

> "Whits the problem? Am a hurtin' any cunt? Naw….a dinnae steal….dinnae bother anybody…am no lyin' aboot wi' fuckin' needles hinging oot ma airms or sellin' shit tae weans…..a ken whit am dain so why the fuckin' hassle?"

Deek was aware of the potential risks of using heroin, which he routinely mitigated by using drugs in the company of one or two friends either at his house or his friends' place. Due to Deeks long-term drug use he felt confident that he would not overdose, which had not happened for "years" and if he did his friend was trained to administer naloxone. After taking his methadone we walked to a café for breakfast then Deek excused himself to meet his "dealer". Surprisingly, the effects of the methadone were becoming evident, and I noticed Deek begin to "gouch".

In summary, Deek's relationship with heroin and methadone is a recurring theme in the findings. He, like Mike, defied the chronic opiate-using stereotype. Deek was well dressed, articulate, and well-kempt, with a strong network of friends; his house was clean, tidy and contemporarily furnished. He described his life as conventional, fulfilling and happy showing no inclination to stop or reduce his drug use, which he did not perceive as problematic. Despite his known drug use, he was not marginalised or ostracised within his community claiming cordial relations with his neighbours and wider members but avoided engaging in criminal activities and shunned those who did. Despite the "inconvenience" and perceived "indignity"

associated with obtaining methadone and its "lack of effect," Deek did not discontinue its use or stop attending SDAS. Deek's explanation which, was routinely noted among participants, was that he took methadone "to stave off withdrawals" should heroin become unavailable although he stated that scenario had never occurred in living memory. Additionally, he highlighted the fact that methadone was "free", a point frequently mentioned as a reason and incentive for its continued use by other participants. While Deek appeared ambivalent about ceasing his methadone when pressed he was adamant, he was not stopping his illicit drug use. His key worker speculated that his mention of stopping methadone and "threatening" to sever ties with SDAS might have been a tactic to negotiate for his preferred weekly script. Despite this, the daily script remained in place and Deek continued his regime.

8.3.3 Billy.

In this section, I introduce Billy, a 64-year-old devout Christian and key informant with whom I spent considerable time. He ranked as the second oldest person I met who used heroin. Billy disclosed that he had been using heroin for over 25 years, although acquaintances suggested he had started during his teenage years. Notably, Billy had pursued a law degree at a prestigious Scottish university before a mutual agreement with the Dean brought about a "period o' interruption", a hiatus that led him to venture into "other endeavours", notably "drug dealing," from which he never returned. He is married with two adult children, both of whom reside at home; neither his wife, a healthcare professional, nor their offspring are involved in substance use. Despite being housebound due to arthritis and COPD linked to smoking, Billy was widely recognised and respected within the community. He lived in a large Victorian flat in central Dumfries and was a level 3 figure (see table 1. chapter 6) in the drug trade. Participants spoke of his alleged connections with organised crime in cities like Glasgow, Amsterdam, and Liverpool, and having "influence". No one I spoke with divulged information purposefully about him or disrespected him in any way; he was simply known as "*the* dealer". Billy quietly reassured me to use his name if *anybody* gave me any problems within the community of people who use substances, "Jist tell thum tae contact me ….or tell thum a will contact thame." His offer, which was without aggression or malice, unwittingly presented an ethical dilemma; I did not doubt his offer to be genuine but did not want it due to concerns that it would affect participant relations. Billy understood why I declined.

Billy stood out as the sole participant in my study who was on a weekly script of 100mls of methadone per day. A substantially higher amount compared with all my other participants

who were on lower daily doses of between 25mls and 75mls. Billy received a higher dose because he is "too intelligent no tae." Billy explains that it is his belief the NHS was there to "help him, no' dictate." He had negotiated this dosage with the SDAS doctor some time ago, citing evidence-based research to support and justify his request for a higher methadone dose. In addition to methadone Billy also used 2-3 wraps of heroin per week ("sometimes mair…"), smoked cannabis, drank alcohol daily and took street and prescribed benzodiazepines when he felt the need, which, like many other people who used drugs, seemed to be daily. Despite his family's disapproval of his drug use and lifestyle, they "accept it" and even supplied him with limited amounts of alcohol. Billy only "deals" when he is at home alone and although his family are not directly involved with Billy's drug career, they chose not to intervene to stop it: i.e., call the police, or leave him.

I met with Billy regularly and was particularly interested in his perspective of the meaning of the concept of recovery. Unlike many other participants such as Mike and Deek who seemed to derive pleasure from heroin use, Billy stated on several occasions that he did not enjoy taking heroin, in contrast to most other participants who did. Billy said:

> "A hate the stuff, a hate taking it but a need it tae function….tae be normal. It's hell oan earth when yi stoap, the pain, the rattles...man yi kin only understan' if yi are an addict. A need it tae function….tae be normal."

These findings are consistent with those Dennis, (2016) found in her London-based study, which highlighted the significance of opiate use to people who use them to attain their "normal" state. Billy's "normal" was achieved by using opiates too, a state eroded as the effects of his heroin wore off. For Billy, heroin was his *meaning* of recovery. Heroin *is* Billy's "normal"; he had accrued more years of his life using heroin than without it.

He self-identified as an "addict" and acknowledged his "spoiled identity" because of his "addiction", citing his lost opportunity at university as an example. He selectively used his diagnosis of "addiction" to access resources, self-identifying as an "addict" when interacting with SDAS professionals. Billy had access to copious amounts of heroin; it was delivered weekly to his home, and it was free to him (a benefit of his status), but he continued to rely on methadone. His methadone was delivered weekly by a pharmacy, achieved through "rational negotiation." But why opt for methadone when heroin was available and free?

> "Minute…. (He scrabbles about looking for something and then finds a penned letter written on lined paper from a jotter). It's fae Dave [a long-standing friend and colleague with a long history of substance use]. He's at a Christian retreat (in Glasgow) tae git him aff the heroin, he's been oan it as long as me, but this is the first time he's come aff in 15 year. They use DF118s, but he says he's been no well [withdrawal symptoms] fur 4 weeks, cannae sleep, gote the shakes, hungry but feels sick when he eats…great holiday, eh? [Laughs]."

Billy passed me the letter to read. Its contents conveyed the misery of withdrawals, an emptiness of life without heroin, and a clear acknowledgement that sooner (and the sooner the better according to Dave) rather than later, heroin will become Dave's focus once more. As I finished reading, Billy subtly raised his eyebrows, he appeared vindicated by the "substance" of the letter, implying, without words, that he wanted to avoid the misery of withdrawal at all costs.

For Dave, life without heroin did not align with the narratives of recovery outlined by scholars like McIntosh and McKeganey (2002), Nettleton et al. (2012), or Witbrodt et al. (2015), nor did it resonate with the aspirations set forth in the Scottish Government's (2008) *The Road to Recovery* strategy. There was no relief expressed in giving up heroin, no sense of achievement, absolution or liberation, and no desire to be or to be considered a contributing member of society in his heroin-free state. The tenets of recovery often cited by people who have "recovered" from substance use disorders such as "wasted years," or how lives "positively change" free from the yoke of heroin and "addiction" (Hanninen and Koski-Jannes, 1999, Best, et al. 2011) were notably absent in his writing. Dave wanted heroin.

Billy then cited a common theme that impacts recovery within the region, one which arose consistently amongst participants, namely their inability to attain anonymity whilst remaining within their local community. This lack of anonymity meant they were unable to distance themselves from "friends" and acquaintances, who were mostly, people who used heroin and did not support their efforts to change their drug using careers.

> "There's nae where tae hide in Dumfries everybody knows whit ye are…. society rejects ye because yer an addict, but yer friends grasp on tae the fact yer an addict, cos

> yer friends are addicts as well. It's easier when yer aw in it the gither. They pull yi back in even when yi are dain' yer damnedest tae stoap, tae git oot…..offer ye free gear, score in front ae yi, undermine yer reasons fur stoapin,' know? Then society rejects yi, even when yer tryin' yer best tae git clean and yi cannae lose the fuckin' "junkie" label nae matter whit yi dae….it's a double whammy…. wan [people who use heroin] disnae want tae let go …..The ither [people who don't use heroin] wants fuck all tae dae wi yi….so yer basically fucked."

Asking Billy if methadone was for his recovery, he smiles:

> "Recovery….what's that then? Recovery for me wid be being… able…. tae…. choose...ma….drugs…of…choice! Tae take what a want, when a want tae, without repercussions or judgements bein' made. Meth is ma safety net…if it all goes tae shit….am no goin' cold turkey….nae chance."

Billy desires the freedom to purchase and use the drugs of his choice. He expresses the opinion that society rejects and stigmatises people who have a substance use disorder even when they are in recovery. At the same time, he highlights his own abundant recovery capital including support from friends, family, his Christian faith, engagement with SDAS, and stability in his home and finances. However, he had no intention to stop or change his drug use. Billy had access to substantial quantities of heroin and hard cash but regulated his use whilst concurrently and successfully trafficking and selling drugs throughout the region, without the need to ever leave his home.

In summary, Billy was a highly intelligent and articulate individual, a devoted and loving husband and father. He maintained a consistent schedule "working" 9-4 Monday to Friday "dealing drugs" from his home whilst his family were out. His drug use was juxtaposed to his immediate, conventional family who did not use drugs and their wishes for him to be drug-free and yet they seemed to accept and arguably enable his drug use. Billy stated he "hates" heroin and unlike many other participants, he self-identified as an "addict," acknowledging his physiological dependence and his family's disapproval of his drug use and associated lifestyle. Throughout our interactions, Billy highlights various barriers to recovery, including the lack of anonymity, the persistent presence of peers using heroin, the ready availability of heroin, and the "horrors" of withdrawal. He also articulates stereotypical attitudes and values

associated with people who use heroin, when discussing his own drug using identity, although these were presented in the third person and none appeared to apply to Billy, given his abundance of recovery and social capital.

For Billy, the meaning of recovery extended to his right of freedom to use drugs, a pursuit that made him feel “normal” when he used heroin. However, his stance was in stark contrast to his family’s views on his drug use, his Christian values and identity, and the lost opportunities he believes he forfeited due to his drug use. Billy’s moral and familial values about drug use and recovery contradicted his physical needs (cravings) and cognitive stance, presenting him with a dilemma he was forced to address daily but one that always erred toward heroin use rather than change. Tragically, Billy passed away very suddenly toward the very end of my time in the field, because of respiratory issues connected with smoking cigarettes.

8.3.4 SDAS recovery perspective.

In this section, I present an analysis of my observations during interactions with SDAS clinicians as I seek to understand their perspectives and how they operationalise recovery. I was invited to attend the weekly “Recovery Clinic” facilitated by a senior staff member of SDAS that offered insight into their approaches. The Recovery Clinic’s remit is to support clients through the process of stopping illicit drug use by offering treatment options such as methadone and guiding them through their change towards eventual abstinence. I believed that (as its title states) the “Recovery Clinic” would introduce me to people actively seeking and engaging with recovery pathways, ceasing heroin, and fulfilling the underpinning philosophies of recovery of both the Scottish Government and SDAS unit. Clients are “invited” to attend every two to three weeks; however, two missed appointments result in methadone scripts being suspended until they do attend.

The clinic is led by an experienced senior mental health nurse (charge nurse) with over forty registered people who use heroin, ostensibly indicating a positive engagement with recovery. However, the charge nurse candidly admitted that the "Recovery Clinic" is, in essence, made up, [whispers] "It’s jist tae make sure they are alright....they are surviving and alive." They acknowledge the clinic’s limitations and explain that the Recovery Clinic offers SDAS staff an opportunity to, “Make share they [people who use heroin] are OK and offer help if we can…no’ thit it’s wanted.” There are clear contradictions between what the SDAS's conceptualisation of

recovery is purporting, what recovery should be, what they offer, and the reality of what recovery means to those who use heroin in rural Dumfries and Galloway.

Operating within the NHS framework, the SDAS is guided by legislation, policy, and professional standards, with allocated funds based on these parameters and the number of people who use heroin they engage with. They implemented *The Road to Recovery* strategy ostensibly espousing static conceptions of structure, that are fixed and inflexible, constructed from recovery policy and legislation, and rigidly emplaced by professional parameters. Clients were assessed and processed; they were presented with options of maintenance (harm reduction) or abstinence, which purportedly led to an unspoiled identity and better life following a brief engagement with services. SDAS workers talked about being committed to implementing *The Road to Recovery* strategy outlined by the Scottish Government, while also acknowledging the futility of forcing people who use heroin to stop using it as such advances were rebuffed, a viewpoint supported by Bartlett, (2016), Benedikt, et al. (2018) and Wincup, (2016). Consequently, their attempts to apply recovery interventions and processes they offered, for instance group work, counselling, philosophies, professional narratives and residential or community detoxification, were <u>not</u> routinely sought or wanted. This was explained by Lucy a SDAS support worker, “Maist o’ thum (people who use heroin) jist want the meth scripts…..they urnae interested in anything else apart fur food vouchers. We try tae get thum involved but…they dinnae want tae ken.” People who use heroin preferred a less structured and undetermined approach to "recovery." They seldom, if ever, framed drug use as problematic or acknowledged and align themselves with "spoiled identities," vehemently rejecting SDAS staff attempts to "rehabilitate" them toward abstinence or changing their everyday practices.

To understand this disconnect I spent considerable time with one clinician, a drugs outreach worker called John, who, unlike other SDAS members, is not a registered nurse. John is in his 50s and has worked for the SDAS for over two decades, providing a needle exchange service, naloxone kits, health education, promotion, and informal counselling to people who use heroin across the region. Unlike the registered nurses, his relationship is not centred on pharmaceutical transactions, such as methadone, or brokering them, and as such he has a quite different, perhaps more informal and personable approach and relationship with his clientele. John extended an invitation for me to accompany him in his car on one of his outreach days to the east of the region. I am only the second person in the past twenty years to have been invited,

the other being a medical doctor a decade ago. John explained his clientele are typically suspicious of strangers, however, those who use heroin within the region apparently knew who I was. News of my presence had been circulated within the drug-using community, and they had granted John permission for me to accompany him during his routine visits.

As we drove to meet John's clientele, he shared the surprising observation that heroin use was, in fact, on the decline in rural Dumfries and Galloway:

> "Smack use is declining….a yased tae gie oot 120,000 needles a year even a few year back, noo….. it's under a 100,000 and a loat ae thame ur fur second and third use [where clients fail to access a vein at the first attempt and try with a new needle], when clients cannae git a vein first time cause their veins ur fucked. Maist ae ma clients ur dyin' oaf and raither than yase smack, youngsters ur yasin' street benzos so they're [people who use heroin] no' bein' replaced….it's simple economics. They ur as well gittin' a dunt fae a tenners worth ae vallies or pre-gab than twinty quids worth ae shit smack. And thae ur aw lookin' fur the next 'hing tae git high oan. Bit the aulder yins ur killin' thumsels wi' polypharmacy, smack, meth, benzos, and booze, fuckin' lethal cos they huv nae idea whit they ur firin' doon there gubs, despite years oan the gear. A wis oot at a regulars and cos they dinnae huv a table a wis oan the flair dishin' oot needles tae this lassie and hur man comes in an sais "open up" an fires 10 street vallies doon hur throat he gote fur a fiver. She swallas wi oot blinkin' and its fuckin half-nine in the moarnin' they ur jist back fae the chemist [pharmacist] an' their meth and he's away fur a cairry oot at ten in the moarnin'" [Scottish licencing laws only allow the sale of alcohol between 10am and 10pm].

Statistics support John's assertion, that heroin use in Scotland is declining (Scottish Drug Misuse Database, 2019). John's perspective is drawn from his longstanding distribution of free needles and drug paraphernalia to clients as part of a proactive response SDAS employ to mitigate overdose, injection-related risks, needle sharing and BBV transmission. He also provides extra needles and paraphernalia to those clients who sell drugs for them to distribute to their buyers, echoing Parkin and Coomber's (2009, p988) theory of "bulk provisions…..as possible conduits to wider harm reduction practice". Furthermore, this model may contribute to prevent shared injecting environments as highlighted by Parkin and Coomber's research. Ensuring the availability of free and accessible injecting equipment alleviates the requirements

for people who use drugs to “rent’ or ‘borrow’ such equipment in shared environments. This reflects the practical implications of this strategy to influence behavioural aspects of drug use and reduce potential harm.

John went on to elaborate that there has been a notable shift in heroin use and drug-related behaviours within rural Dumfries and Galloway. In the recent past, there were distinct demarcation lines separating people who use drugs and those that use alcohol; those who drank alcohol stuck to alcohol, those who used recreational drugs indulged in recreational drugs, and people who engage with heroin use, used heroin exclusively. John highlighted a clear and discernible drug hierarchy associated to this, similar to a hierarchy reported by Kopak, et al. (2017). Recreational drugs were for “partygoers”, and “alcoholics” were deemed “beneath them.” They, however, were “better than” those who used heroin who were, according to John, considered the “lowest of the low” by both local people who used recreational drugs and “alcoholics” alike. Even within the realm of those who used heroin, John identified a sub-hierarchy:

- Occasional “heroin users” were perceived as the least offensive.
- Regular "heroin users" who regulated their use and were not involved in criminal activities (either employed or more likely receiving benefits) were next.
- Regular "heroin users" who regulated their use but engaged in criminal activities such as dealing and shoplifting followed.
- “Giro junkies” characterized as unregulated and chaotic "heroin users" by John, who claimed they would "Sell their grannies for a dunt," were considered the most offensive.

Hamersley and Reid, (2002, p.23) clarify the label “giro junkies”:

> “Glaswegian drug injectors have a scornful label “Giro Junkie” which refers to drug injectors who spend much of their benefit cheque on drugs, then more-or-less abstain until the next cheque. “Real Junkies” scorn “Giro Junkies” because obviously they are not really addicted, they can go without drugs and are not even addicted enough to have to steal”.

People who use heroin, like Mike and Deek, for instance, do use their government benefits (giros) to purchase heroin, but they regulate their heroin use and consciously refrain from engaging in criminal activities for income generation. They express a particular disdain for

people who use heroin who resort to theft from acquaintances or members of their community, as such actions risk involvement with the criminal justice system and may incur disapproval from people who did not use substances within the community. During my fieldwork, I did not encounter individuals fitting the description of "giro junkies." This absence may indicate that such behaviours are more prevalent in urban areas, or it could be a result of limited contact with such individuals in the region because they did not engage with SDAS. Additionally, certain behaviours commonly associated with urban drug use, such as shared drug-using environments, outdoor drug use, rough-sleeping, muggings, and street dealing, were not prominently observed in my study.

John's evidence and my analysis of other data reflect the fact that (once clear) drug-using demarcation lines are now blurred, and poly-substance use is commonplace, a point reflected in other studies by authors such as Moss, et al. (2016), Morley, et al. (2017) and Liu, et al. (2018). John explained that local changes to heroin use are due to a combination of "simple economics" and the oft-mooted poor-quality heroin, reported by people who use it. Poor-quality heroin means people who use heroin are more likely to use other drugs such as street benzodiazepines and alcohol to attain their desired high. The combination of poor-quality heroin and ever affordable and accessible "street benzos" (Diazepam and Alprazolam) saw a paradigm change from around 2016/17, although John felt it to have been longer and more gradual, but it did affect all those who used drugs that he knew:

> "People who use heroin ur takin gear, meth, benzos, pregabs and booze…..the chinges tae alcohol ur makin' it harder and mair expensive tae git booze fur yer average alcoholic…so in that respect they [new alcohol laws] ur workin.' Bit….if ye cannae git booze, then like any addict, yer gonna git the next best 'hing….in this case fuckin' street vallies and pregab. Naebody kens whit they ur takin' bit they take it anywey and the results ur there fur everybody tae see [increase in overdoses and drug-related deaths]. Yi take away yin 'hing and 'er is always sumthin' tae fill the void. Then there's the fuckin' recreational users, coke, and speed maistly, they ur fuckin' hypocrites……they will snort hunners ae pounds up their noses and fuckin' call people who use heroin junkies (scoffs)."

John illustrates a point highlighted by Jaffe, et al. (1980) that "addicts" adjust their drug use depending on availability. In Dumfries and Galloway, heroin availability had not diminished

despite a decrease in its use. Poly-substance use was commonly reported, but this surprisingly often excluded heroin use, only street benzodiazepines, pregabalin, methadone, recreational drugs such as cocaine and alcohol coinciding with an increase in the region's drug-related deaths. Regardless, people who use recreational drugs but not heroin, according to John, retained a negative perception of heroin and those who used it, consequently (positively) limiting their own engagement with it. Poly-substance overdose poses challenges in treatment due to the uncertainty of drugs consumed and the various "antidotes," such as naloxone, needed to reverse their effects. Jones et al. (2012) and Gili et al. (2022) suggest that poly-substance misuse requires tailored and individualised recovery treatment pathways.

SDAS reported intensifying their efforts, including additional appointments and methadone prescriptions, to counteract the region's rising drug-related death toll. However, the SDAS rarely engaged with people other than those with heroin "addiction" or alcoholism. The extra input, however, did not have the desired results, with drug-related deaths attaining, and then maintaining a record level within the region from 2018 onward. Heroin related harm indicators such as health issues and violence, were noted to be reducing. Two important factors were apparent as a result. Firstly, a negative impact on SDAS workers' morale (more referrals, more deaths and related emotional impact this had on the SDAS staff). Secondly, despite the record number of drug deaths, there was no discernible positive impact on those people who used drugs, i.e. seeking to abstain from or reduce their drug use in partnership with the SDAS to reduce the risk of overdose and death.

One consequence of increased poly-substance use was that, although the SDAS increased their numbers of methadone prescriptions, they reduced prescription dosages to minimise the risk of overdose and potentially related deaths. A reduction in methadone dosages, according to John, led to people who use heroin disengaging with the SDAS, forgoing methadone and any potential benefits because the perceived benefits of attending the SDAS or pharmacy were outweighed by their "low dose of methadone", "inconvenience", and "indignity." Ironically, as the numbers of "registered" SDAS clients decrease (through deaths, or disengagement), there is a reduction in methadone prescriptions and registered clients, creating a false impression of the effectiveness of the SDAS interventions and Scottish Government's drugs recovery strategy. The anomaly lies in the fact that while the numbers of "registered" people who use drugs appear to decrease, drug-related deaths (specifically where older people with chronic heroin use who are not familiar with new drugs or drug-taking regimes) increased

throughout the region. This was primarily attributed to heightened poly-substance use, as traditional demarcation lines among people who use drugs have become so blurred, leading to further declines in registered people who use drugs and methadone prescriptions at the SDAS. After all, methadone is prescribed only when heroin is used.

Reports from my participants corroborated John's observations, people who use heroin, like Mike, Deek and Billy do not consider or relate recovery to detoxification or abstinence as set out by the Scottish Government's recovery strategy. In fact, according to John, they do not consciously contemplate recovery at all:

> "They [people who use heroin] ur jist like you an' me, bit take smack….a like a beer, they like a wrap, know? Am no gonna gie up a beer and aye, sometimes a git hammered and make a cunt ae masel' but that's life, am a gonna refer masel in tae Cameron Hoose? Course am no… bit they huv tae, tae git meth, and that's the only reason they go."

Like Billy, John attested that people who use heroin are no different to those who do not (a point I routinely noted in the data from participants and in drug research studies, see Nettleton, et al. 2012; Boeri, 2004) but face routine "discrimination" because of social and legal attitudes towards heroin, those who use it and its use. John's belief was confirmed by the fact that people who use heroin must regularly visit SDAS and pharmacists to obtain methadone. He went on to state; "Recovery fur the service is simple, statistics. It's keepin' the punters alive that's where aw the resources ur focussed at. Fur the punters it's aboot getting a dunt." Recovery, from John's perspective as a healthcare professional is simply stopping his clients from overdosing and dying. Keeping people alive from day-to-day, week-to-week is his sole focus because he is attending funerals, "Far too fuckin' often."

In summary, the recovery clinic plays a crucial role in maintaining contact with people who use heroin, aligning with the service strategy, and ensuring continuous communication with their clientele. However, my participants did not view the recovery clinic as central to their recovery, they did not consider recovery at all, and perceived it, along with the SDAS itself, as an inconvenience. John contends that the concept of "recovery" is a dogmatic belief espoused by those who do not use drugs who are hypocritical when they themselves usually smoke, take alcohol and occasionally recreational drugs. He does not label his clientele as "addicts" and is firm in his belief that they do not present or self-identify as such. Perhaps, as a result, they do

not seek nor do they wish to embark upon recovery pathways imposed upon them, as John questions, “what dae they huv tae recover from then?”

8.3.5 Locating the meaning of recovery for SDAS staff.

In this last section, I look to locate what meaning recovery has among the SDAS staff tasked with operationalising and implementing *The Road to Recovery* strategy. Originally, my plan involved meeting participants through snowball sampling, but this proved unsuccessful, as detailed in the methods chapter. Consequently, I relied on SDAS staff to facilitate my access to people who use heroin in the region, leading me to spend time with the staff as I awaited introductions.

My analysis reaffirms that, consistent with my previous findings, people who use heroin in rural Dumfries and Galloway do not actively perceive "recovery" as synonymous with abstinence; in fact, they do not consider recovery at all. Most of my participants do not self-identify as "addicts." This aligns with contemporary evidence, highlighting the ongoing debate surrounding addiction and recovery among scholars, professionals, and people who use drugs (Lancaster, et al., 2015; Neale, et al., 2014; MacGregor, 2012). Despite most of my participants having some level of engagement with the SDAS, the concept of recovery, as defined by the Scottish Government as "a drug-free life," remained an alien concept to them. People who did discuss recovery often framed their narratives based on what they believed clinicians wanted to hear. In doing so, they presented a “performance” tailored to meet the expectations that would secure methadone or access to benefits and resources associated with "addiction."

Interacting with SDAS staff provided an opportunity for me to explore their perspectives of recovery and to understand why people who use drugs in the region constituted a non-voluntary clientele group from a “street-level bureaucrats” perspective, a perspective often overlooked in recovery literature. Recounting recovery, Debbie, a mental health staff nurse asserted that “Recovery is whatever they [people who use heroin] want it to be,” whilst her colleague Stuart, a senior mental health nurse believed “Recovery is individual to the client.” Debbie and Stuart were neither definitive nor prescriptive about recovery, placing the emphasis of recovery on their clients and their understanding of it. Evelyn, a veteran SDAS healthcare support worker, following careful consideration, admitted, "am no sure what recovery means." Emma, an SDAS nurse and former addictions nurse in Glasgow for three years, summarised:

> "Doon here [Dumfries and Galloway] recovery is what the (service) user thinks it should be…..but how does that work? They don't have the resources [In Dumfries and Galloway] so it's methadone or Subutex *if* they [people who use heroin] jump through the hoops…. and (then) they are back in the same environment …so they take heroin….."

Recovery resources for people who use heroin within the region are limited to the SDAS, which has access to two detoxification beds within an acute mental health admission unit at the local mental health hospital for residential detoxification. NHS service needs, however, mean that even pre-booked detoxification, after months of waiting, are routinely cancelled at short notice because priority is given to "at risk" mental health patients. SDAS staff pointed out that detoxification admissions are predominantly for "alcoholic" clients, primarily due to waiting times and ongoing engagement. John explained that recovery resources are non-existent beyond the SDAS unit, which serves as the sole provider of substitute medication.

Resources within rural Dumfries and Galloway sharply contrast with those available in an urban environment such as Glasgow. Emma highlighted that Glasgow had a plethora of 24-hour services, including residential detoxification and walk-in clinics "you kin get help roond the clock in Glasgow….pretty much 365 days of the year." There are also services which target specific groups within the substance using community, such as women (Glasgow City Council, 2019; Scottish Drug Forum, 2019; Turning Point Scotland, 2019). In Dumfries and Galloway, third-sector recovery services for people who use heroin are limited to Add-Action and Alcohol and Drugs Support (ADS) Scotland, both operating from 9am to 5pm, Monday to Friday. While they offer similar services like counselling and benefits support, neither provides methadone prescriptions. Beyond the time boundaries of 9am – 5pm Monday to Friday, there were no specialist recovery services available to people who use heroin, except for Accident and Emergency, which offers free emergency medical care. James, a 38-year-old who uses heroin intravenously from Newton Stewart, expressed that because Add-Action and ADS only offer counselling and do not prescribe methadone, they are perceived as being "Jist fur jakeys" [alcoholics].

The potential impact a lack of resources has on recovery, as highlighted in Hser, et al.'s (2007) longitudinal study of (n242) people who use heroin in the U.S., is substantial, potentially undermining the sustainability of recovery. Hser et al. cite resources as having a pivotal role in

initiating, attaining, and sustaining recovery. In contrast, Best et al.'s study in the U.K. (2008, p.619), involving 107 people in recovery from heroin use, revealed that "Treatment was not mentioned widely either in achieving or sustaining abstinence." This finding is corroborated by Humphreys (2015, p.1024), who supports this perspective by asserting, "The myth that treatment is necessary for recovery has no empirical support." Despite health professionals like Debbie and Stuart recognising the lack of recovery resources and consequently advocating for more, such as specialist residential detoxification units, to enhance and present diverse recovery pathways, their perspectives remain ambiguous regarding the meaning of recovery. Participants in my study did not express concerns about the availability of resources or their impact on recovery pathways. In fact, participants consistently stated their unwillingness to engage with the free resources available to them. The lack of resources did not result in an increase in reported drug-related deaths. Contrary to my expectations, the statistics aligned per capita with those of well-resourced urban areas.

A disinterest in available resources and a disregard for others may of course be because participants in my study were active in their heroin use. They were not seeking to stop their drug use, with Dunn, et al. (2019, p.25) highlighting, the fact that “patients do poorly in real-world detoxification settings”. Active heroin use, as noted by Biernacki (1986), does not preclude engagement with practices associated with recovery, a point reflected by my participants who used heroin and attended SDAS. John clarified the reasons he believed people who use heroin engage with SDAS, “If it wisnae fur methadone nae cunt wid gaun, fuck aw tae dae wi’ yer fuckin’ recovery” (looks at me with disdain). Participants did not consistently view themselves or their drug use negatively; they were not inherently problematised and appeared accepted by their broader communities, which was in part because they grew up there.

Certain behaviours, however, such as public heroin use created friction between those who used heroin and members of their communities who would confront or even inform the police, thus reinforcing conformity. In essence, this dynamic contributes to a social construct, as suggested by Lindesmith (1968) and Stephens (1991) that encourages people who use heroin to self-regulate and modify their heroin use and associated behaviour to maintain social status and acceptance. However, my analysis revealed that the lack of complete anonymity prevented participants from presenting as entirely "acceptable" or in effect, as people who did not use drugs, as their drug use could not be concealed. The impact this had on recovery was to lessen the negativity associated with heroin use amongst local communities and consequently,

reducing societal pressure for rural people who use heroin to consider change, relocate or to stop their drug use as there were no immediate social consequences.

In summary, SDAS healthcare professionals exhibit an ambiguous understanding and application of recovery, emphasising and promoting stability rather than change. They place the onus of change on their clientele who, in turn reject recovery pathways. This highlights a clear disconnect between the political application of recovery, as part of *The Road to Recovery* strategy, what meaning recovery holds for rural people who use heroin and what meaning recovery holds for professionals from the SDAS. John, the outreach worker, explained that the region's people who use heroin do not problematise their drug use or lifestyles (as consistently observed in data) arguably negating any perceived need for recovery services. This lack of perceived need, in turn, may contribute to the scarcity of recovery resources available throughout the region. Healthcare professionals at the SDAS navigate between the binary positions of people who use heroin and political strategies, utilising methadone as a means of engagement and retention, which may be viewed as a form of coercion. Nevertheless, the relationship between healthcare professionals from the SDAS and rural people who use heroin is a facade; both parties comprehend their roles and expectations, ensuring that they perform their roles so each can extract what they need from the arrangement, resulting in a delicate and balanced connection.

8.4 Chapter conclusion.

In addressing my third objective, which was to explore the meaning of recovery for people who use heroin in rural Dumfries and Galloway, my findings reveal a distinct dichotomy between political and cultural paradigms regarding drug (specifically heroin) use. Participants, even while engaging with recovery services, do not perceive themselves as "in recovery." In fact, they consistently express they do not consider recovery at all. Despite long-standing habitual drug use and regular contact with recovery services and associated recovery capital, most participants reject the labels of "addict" and "spoiled identity." Some, like Billy, did self-identify as an "addict" and recognised how this label, along with their drug-related behaviours, affected their interactions with and how they were viewed by those people who did not use drugs. The "addict" label plays a crucial role in securing access to resources like state benefits and prescription methadone. Consequently, it is vital for participants to actively embody and perform their roles as "addicts" to ensure the continued availability of these resources. The "parameters" of recovery, outlined by scholars such as Lancaster et al. (2015), Neale et al.

(2014), and Witbrodt et al. (2015), manifest in the everyday practices of people who use heroin, which encompass harm reduction and recovery capital such as recovery services, methadone, housing, and state benefits. Participants, even those identifying as "addicts" like Billy, do not perceive drug use or their associated lifestyles as problematic and thus see no need for change. They routinely expressed their quality of life was such that heroin abstinence could not and would not improve it and that their lives even with heroin and its associated harm indicators and risks are in the main conventional, happy, and fulfilling.

The SDAS, although espousing the Scottish Government's *The Road to Recovery,* doctrine of abstinence and a "drug-free" life, was committed to and maintained a harm reduction philosophy. Participants were offered methadone by the SDAS, used as leverage to "persuade" ongoing engagement with services to stabilise their drug use, even as clients continued to use heroin, street drugs, and alcohol. Despite acknowledging that methadone provided little benefit and acquiring a script was inconvenient and degrading, participants did not actively seek to reduce or stop their methadone use. Equally, the SDAS did not place an onus or impose an obligation on those people who used heroin to stop or reduce their illicit drug or methadone use. This led to prolonged periods of drug use without the requirement to stop or titrate their methadone or heroin or participate in optional recovery-oriented interventions. Notably, neither participants nor SDAS staff expressed a clear understanding or responsibility for recovery.

Finally, it was evident political pressure was being exerted from the Scottish Government on recovery services throughout Scotland to address the rising drug-related deaths. This prompted the SDAS to prioritise a central doctrine and mantra to prioritise life over other aspects of recovery which they arguably were successful in achieving despite limited resources in comparison with resource-rich services such as those in Glasgow. The Scottish Government's policy on abstinence and "drug-free" lives could be viewed as an act of "symbolism" in this narrative, thus quelling social concerns with regards to drug use and related deaths. The SDAS's use of methadone to coerce ongoing engagement with people who use heroin arguably proved a successful strategy in reducing drug-related deaths in the region, even if it did not lead to abstinence.

Harm reduction equipment store at the SDAS awaits restocking. Spring 2018.

Chapter 9: Discussion and Conclusion.

9.1 Introduction.

My research focused on investigating and understanding heroin use, its patterns among individuals, and what recovery means to people who actively use heroin, within the rural setting of Dumfries and Galloway, within the context of the then Scottish Drugs Policy; "*The Road to Recovery"* (2008-2018) (Scottish Government, 2008).

The research objectives were:

1. To investigate how people who use heroin in a rural setting acquire, administer, and fund their heroin use (chapter 6).
2. To investigate the use of heroin in the context of "everyday life" in a rural setting (chapter 7).
3. To explore what meaning recovery holds for people who use heroin in a rural setting (chapter 8).

In relation to research objective one, I discovered both heroin and its use is pervasive even within the most remote areas of rural Dumfries and Galloway. The unexpected availability of heroin even within the most remote area of the region aligns with Janssen's (2017) study of people who use heroin in rural France, which reported increasing availability within rural settings. This finding reinforces Robbins's (1993) study, which identified similar trends several decades earlier, highlighting its continuing trajectory. However, heroin use was found to have been supplemented by the increasing prevalence of "street" benzodiazepines, cocaine, and alcohol, even among older individuals who reported chronic heroin use. I observed stark contrasts in the identities, recovery capital and everyday practices of people who use heroin in this rural setting compared to findings from studies by scholars, such as Biernacki (1986), Granfield and Cloud (2001), Neale et al. (2012) and Nettleton et al. (2012) conducted in urban settings. The procurement and purchase of heroin, which was prevalent, was straightforward for people with established connections who were "known." They relied on social media and mobile telephones to facilitate transactions. Transactions, in line with developing technology, transcended traditional cash sales to include PayPal, Apple Pay, and bank transfers, and commonly extended to credit and "gifts" also. Gifts, similar to those described by Mauss (1950), created a sense of obligation among participants and reinforced drug-using bonds.

Unlike studies by Bourgois, (1998) Parkin, (2013), and Hoffer (2016), which reported that violence was common among people who use drugs, I found little evidence of discord or violence among my participants or the wider community of people who used drugs. Heroin use was typically regulated and controlled, aligning with Weinberg's (2002; 2022) stance, and commonly administered within the confines of people's own or a friend's home. This contrasts with findings from scholars such as Rosenbaum (1981), Fraser and Moore (2008), and Sun et al. (2016), who portrayed the lifestyles of people who use heroin as chaotic and characterised by unregulated use. These factors along with a lack of anonymity and small community of people who use heroin dispersed over a large geographical area contributed to the lack of reported violence. Heroin consumption involved inhalation (known as "chasing the dragon") and more commonly intravenous injection, using sterile equipment provided by the SDAS, which also provided free methadone prescriptions. Unlike the studies by scholars such as Pearson (1987), Stephens (1991) and Neale, et al. (2009) of people who used drugs in urban settings, whose income generation largely relied on criminality, my participants primarily relied on fortnightly state benefits, supplemented by selling small quantities of drugs, informal employment within the cash-in-hand gig economy, and, very infrequently, theft, which they did outside their communities. These findings were largely unexpected, and challenge contemporary narratives on drug use, mostly drawn from urban settings and focused on people "in recovery" or "recovered" while also enriching the research on drug use in rural settings.

In relation to research objective two, although heroin use pervaded the everyday lives of my participants, for the majority it did not dominate their everyday practices. They routinely regarded their identities and lives as "normal" and comparable to those people who did not use heroin, routinely rejecting identities that were "spoiled". My participants held everyday roles, identifying as parents, partners, friends and employees within their communities, not as "addicts". They regularly engaged in social interactions, leisure activities, and mundane everyday practices such as shopping and household chores. As Nettleton et al. (2011a) and Neale et al. (2012) found, these roles are central to a sense of normality as they align with societal expectations. However, my participants believed that these everyday roles could be maintained alongside heroin use, viewing abstinence as unnecessary for achieving normality. It was evident from my observations that people who did not use drugs in their communities

similarly did not identify or label my participants as “addicts,” despite knowing about their heroin use, which reinforces the notion that societal norms and values can shape perceptions of drug use and recovery both negatively and positively. This aligns with Nettleton et al.'s (2011a) study, which highlighted the socially constructed nature of normalcy and how her participants aspired to be perceived as "normal" within societal parameters. Nettleton et al. (2011a) argue that people in recovery from substance use strive to achieve a sense of normalcy, with everyday practices and routines contributing to the social construct concept of normalcy, influenced by social, cultural, and historical contexts. However, unlike Nettleton et al.'s (2011a) findings, my participants sought to achieve a sense of "normal" while continuing to use drugs, drawing on the available recovery capital, which they largely succeeded in doing. Identifying as "normal" functioning members of society, they lived everyday lives, supported by recovery capital in the form of benefits and recovery resources provided by SDAS, and were generally free from stigmatisation within their communities.

However, my participants were observed “performing” addiction and adopting and portraying an “addict” identity, often exaggerating and feigning symptoms, when obtaining recovery capital, such as syringes, methadone and benefits, but reverting to their usual selves when this role was no longer needed, re-identifying as “normal” within their communities. My participants performed an “addict” identity to access essential resources and to ensure these were not reduced or stopped, and because there was no alternative recovery service that supplied methadone. Juxtaposed to their performance was the role of the SDAS, who also engaged in this dynamic by listening and assessing participants while being equally keen to ensure resources were provided and utilised to promote stability, engagement, and who could increase or decrease resources to participants but were focussed on reducing drug associated harms such as blood-borne viruses, overdose, and deaths. Drug use was also found to be countenanced by strong connections to family, friends, and the wider community, and a strong desire to remain resident in their local area while continuing their drug using careers, aligning with findings noted by Smith (2014).

Despite the availability and accessibility of heroin, I found that its consumption was generally regulated and controlled among my participants, similar to the controlled drug use highlighted in urban drugs studies by Biernacki (1986) and Bourgois (1995; 1998) and influenced by the SDAS. This regulation was considered pivotal in preserving stability for many individuals and ensuring a sense of equilibrium between those people who used drugs and those who did not.

This finding challenges narratives from Dietze et al. (2005), Darke et al. (2007), Strang et al. (2016), Sun et al. (2016), and Burhan et al. (2019), which report that heroin use is chaotic and uncontrollable. Rural living also presented many inherent challenges, such as poor transportation, lack of anonymity, inadequate infrastructure, and wide geographical areas, which combined to exacerbate the risks of illicit drug use. These factors contributed to chronic drug use, lone drug use, criminality, overdose, and physical and mental health issues, sometimes resulting in death. Despite these challenges, rural living also provided opportunities that Nettleton et al. (2011a) cited as significant for recovery. For example, my participants had stable housing, social connections, and, for those who sought it, access to employment opportunities, which all speak to locating recovery and normalcy.

In relation to research objective three, heroin use was not problematised by my participants, aligning with findings by Zinberg (1984), Biernacki (1986), Orford (2001), and Berridge (2013), who reflect that not everyone who uses heroin becomes addicted and reinforcing some people can use heroin in a controlled manner. Consequently, the concept of recovery as abstinence, as defined in the Scottish Government's 2008 *The Road to Recovery* strategy, held no discernible meaning for them, subsequently they did not aspire to recovery in the context of stopping heroin use. Participants rejected "spoiled identities"; thus, they had nothing to recover from. Some participants expressed a desire to stop using heroin, but this sentiment, in collaboration with performing an "addict" identity, was primarily a strategic response to access or ensure ongoing access to benefits, methadone, and injecting equipment rather than a genuine desire for abstinence. Recovery capital was free and provided without obligation. Thus, engagement with recovery services was motivated by practical need rather than a commitment to stopping drug use. Although the SDAS philosophy emphasised abstinence, in practice, it operationalised recovery as stabilising drug use and preserving life by reducing the risk of overdose and health-related issues such as blood borne viruses through methadone maintenance programmes, sterile injecting equipment, needle disposal tubs, provision of naloxone and ongoing SDAS engagement. Contrary to previous research on recovery, by scholars such as Zinberg (1984), Biernacki (1986), White (1998) and Best et al. (2011), which has primarily focused on the experiences and views of people in recovery, and despite the prevailing push towards recovery-oriented systems of care in Scotland at the time of data collection in 2018, my findings reveal a surprising insight: participants wanted to continue their everyday lives while still using heroin and other drugs.

I found people who maintained stable patterns of substance use, had stable housing, and access to free health and recovery services, while remaining integrated into their communities, were not actively seeking recovery. They experienced what I have termed "recovery inertia," as there was no evidence of either strong push or pull factors towards abstinence-based recovery. My findings also reflect Weinberg's (2022) argument that mainstream addiction science tends to oversimplify addiction and recovery. This mainstream perspective often problematises the complex interaction of drugs, drug-using environments, and legal frameworks, while overlooking the diverse individual pathways people take and do not take in their experiences of drug use, addiction, and recovery. Neale et al. (2013) also posit recovery-oriented systems of care risk prematurely pushing individuals into detoxification, potentially leading to relapse, a process they advocate that should be guided by the person. This may lead to longer term use of methadone, but Frank (2017, p.163) found that methadone can serve to "moderate or escape from those harms" associated with illicit drug use. My findings, align with White (1998) and Neale et al. (2013) in supporting person-centred approaches, made possible by a rural setting, which afford individuals greater autonomy and flexibility in navigating recovery pathways. They also highlight the contrast between datasets from individuals in recovery and those actively using heroin, and their notable lack of motivation toward abstinence-based recovery, despite the resources available to them.

This can, perhaps, be explained by three generated findings. Firstly, despite having access to heroin and funds to purchase it, participants mostly regulated and controlled their use. The close-knit nature of rural communities in Dumfries and Galloway eliminated anonymity, yet participants chose to remain within their communities, maintaining familial and friendship ties while moderating their drug-related behaviours and activities to avoid conflict or police attention. They prioritised these relationships and their rural setting over heroin use. Secondly, individuals in rural areas did not typically turn to criminal activities for income generation. Instead, they relied on state benefits, which placed them on an economic level with “average earners” in Dumfries and Galloway. The lack of anonymity deterred theft, violence and criminality, and combined with the easy availability of seasonal employment in agriculture day labour, led to individuals supplementing their income through participation in the gig economy, sharing drugs or selling small quantities of heroin. Finally, abstinence was neither pursued by participants nor expected by recovery services. People were economically secure, homed, socially connected, and had employment opportunities but showed no interest in pursuing

abstinence. Participants engaged with the SDAS for methadone prescriptions and drug-using equipment. However, methadone was not viewed or used by participants as a pathway to heroin cessation. Instead, it, along with drug-using equipment, was valued for being free, readily available, and effective in preventing withdrawal symptoms in case of heroin scarcity, and significantly reduced risk associated harms. This approach, consequently contributed to its long-term use.

In the following section, I delve deeper into key insights, bringing my thesis together as a whole before considering potential implications and avenues for future research and practice. I conclude with a discussion on the limitations of my study and offer my final thoughts.

9.2.1 The impact of rurality on the everyday lives and recovery of people who use heroin.

My analysis reveals that living in a rural setting presents unique challenges and opportunities for people who use heroin. These challenges and opportunities my participants experienced, routinely integrated and normalised into their everyday practices, significantly shaped their everyday lives and practices, influencing their framing, understanding, and engagement with drug use, addiction and recovery. Dumfries and Galloway, like many rural areas as Tuan (1976) notes, exhibits a slower pace of life and a cleaner, greener environment supporting person-centred approaches which were specific to rural settings. My participants adeptly incorporated the rural environment and rural living into their lives, surmounting obstacles and taking advantage of the nuanced opportunities it presented.

Public transport, particularly buses, played an indispensable role in facilitating commuting across the region, inadvertently shaping the daily practices of people who use heroin. While buses were essential for commuting, they were often unreliable, infrequent and had long journey times, significantly impacting participants' daily lives, especially through the winter months. Contrary to research that cites public transport as a negative source of interactions with fellow commuters and transport staff due to stigma associated with people who use heroin (see Rhodes, et al. 2006; Stevens, 2010; Neale, et al. 2012) my findings reflect bus travel often promoted integration and social bonding. Relationships were observed to be affirmed, participants' identities were reinforced as community members, sons, daughters, friends and parents rather than "drug addicts." Gossip and banter were commonly exchanged among commuters, further enhancing social interactions. Participants also had to be capable of using

buses, often daily, sometimes travelling for several hours not only to procure heroin but also to access healthcare, purchase groceries, get to work and visit friends and family. Commuting via public transport determined when and how heroin could be trafficked, procured and used, unexpectedly necessitating regulated use. Methadone functioned as a crucial "safety net" against withdrawals, but obtaining it entailed traveling within the 9-5 operating hours of the SDAS and pharmacies. To reduce time and travel costs, participants, somewhat paradoxically, routinely combined trips to purchase heroin with visits to recovery services (SDAS or pharmacies) for methadone. Methadone staved off withdrawal symptoms supporting participants to return to the security of their homes to administer heroin.

As we have seen, anonymity is difficult to maintain in rural settings. Their substance use identities, practices, routines, and lives were widely known in their small, close-knit communities. Despite this visibility, they were neither ostracised nor marginalised as they were in urban based studies such as Biernacki's (1986) or McIntosh and McKeganey's. (2000; 2002). Even when individuals relocated within the region, their backgrounds quickly became public knowledge through family, friends, and social media, yet usually led to a fairly seamless integration into their "new" communities. Opportunities for recovery that relocation potentially offered for instance, avoiding places, people, and situations associated with drug use considered essential for recovery by scholars such as McIntosh and McKeganey (2000), Granfield and Cloud (2001) and Doukas and Cullen (2009), were quickly negated, however, as contact with previous acquaintances who used drugs continued due to existing friendships and drug-related bonds. Additionally, new connections with people who used drugs at a local level were made, leading to continued drug use and a sense of hopelessness (Alexander, 2010), with regards to potential recovery pathways. Having a known drug use identity drew scrutiny from local police, who were believed to monitor activities of new drug using residents to prevent drug-related behaviours from affecting people who did not use drugs. As a result, individuals were more secretive, leading to solitary drug use and a higher risk of overdose.

My participants consistently conveyed to me, and I observed, their inability to secure or sustain anonymity, a factor commonly cited as pivotal by NA (1997). They expressed a reluctance or incapacity to hide, deceive, alter or shed their "addict" identities within their rural surroundings; there was simply no point. Despite their spoiled identities and known drug use, they were included and, in some cases, protected by the communities in which they lived. My

findings challenge mainstream identity literature such as, Waldorf and Biernacki (1981), Biernacki (1986), McIntosh and McKeganey (2002), Radcliffe and Stevens (2008), and Neale et al. (2011), pertaining to stigmatisation and social exclusion relating to spoiled identities. It does demonstrate the pivotal role community can play in constructing identities and supporting people who use heroin. Neale et al. (2011) wrote that a new identity requires a new lifestyle, a new environment, anonymity, and termination of associations with people who use drugs. However, my participants could not and as Smith (2014) found, did not want to relocate away from their friends and family. As with Biernacki's (1986) findings, my participants were not motivated to be drug-free, they did not feel they had spoiled identities, and generally did not experience stigma. Consequently, they did not report they were not ostracised, marginalised or isolated which meant they did not have identities they wanted to change. If, like Rhonda, their behaviours impacted their communities through violence or blatant criminality, they were marginalised. However, such marginalisation occurred regardless of drug use. These behaviours were simply seen as anti-social, and the perpetrators were marginalised until their behaviour changed or they were expelled from their communities.

Consequently, participants reported being transparent about (albeit not flaunting) their drug-using identities and lifestyles, which contrasts findings from studies such as, Biernacki (1986, Mcintosh and McKeganey's. (2002) and Neale et al. (2012) that locate people who use heroin as secretive. Despite having a known "drug-using identity" participants and their families were routinely invited and welcomed to social events, greeted cordially by neighbours and were integrated into their communities. Personal identity transformation considered necessary for developing a recovery identity and sustaining long-term behavioural change or abstinence through social reintegration, social networks and community involvement (see Biernacki, 1986; White, 1998, 2007; Hill and Leeming, 2014; Dahl 2015; Best, et al. 2015; Bathish, et al. 2017 and Earp, et al. 2019) was not apparent where social integration was already established, drug use was regulated and controlled, and anonymity absent. The absence of anonymity also underpinned regulated heroin use, as drug-related activities and behaviours were modified to ensure and sustain acceptance and inclusion within their rural communities. Some participants with urban backgrounds, echoing findings from Adler, (1992) and Bourgois and Schonberg (2009), reflected on their ability to relocate within short distances in a city to regain anonymity if desired. However, they opted to move (back) to their rural communities, citing familial support, friendship ties, increased social capital (housing, state benefits, and a lower cost of

living), and a sense of safety and belonging. This aligns with Granfield and Cloud's (2001) and Cloud and Granfield's (2008) position on the beneficial impact of such capital on recovery.

The rural setting posed challenges for my participants, some of which aligned with those commonly found in urban contexts, such as overdose, drug-related violence, physical and mental health issues, and at a population level, reports of increasing drug-related deaths, even among older and historically stable people who used heroin. Except for the health issues identified by Rhonda, leg ulcer, deep vein thrombosis (DVT), and more commonly blood-borne virus (BBV) hepatitis C, I did not personally observe these challenges, but they were reported by participants. The infrequency or invisibility of these challenges, compared to those found in urban studies (see for instance Gryczynski et al., 2009; Neale et al., 2012; Briggs, 2014), may be attributed to the distinctive nature and structure of rural settings, coupled with the agency of rural actors.

Analysis revealed that people who used heroin in rural Dumfries and Galloway shared factors routinely associated with drug-related harm and spoiled identities as identified by scholars such as Biernacki (1986), McLellan (2010), and Best et al. (2015). These included easy access to heroin, limited recovery services, poly-substance use, older individuals with a history of substance use, and geographical distance from medical and recovery services. Notably, I did not observe and there were no reported cases of outdoor drug use, rough sleeping or “street dealing” often associated with heroin use in urban settings (See Bourgois 1995; Briggs, 2012; Parkin, 2013). Participants used their homes for drug administration, negating the need for shared environments, and I consistently observed strong familial ties, inclusion, and acceptance within their rural communities. Perhaps because of a wide range of free recovery capital and rejection of drug using identities, police were often reported by participants to exhibit empathy toward them. These mitigating factors may also contribute to the lower incidence of drug-related deaths compared to most urban settings, potentially offsetting the limited recovery services provided by SDAS. Towards the end of my study, however, there was a notable increase in the availability and use of inexpensive "street" benzodiazepines, coupled with increased alcohol consumption among participants who had previously only used heroin and methadone. This shift in patterns of use coincided with the region's escalating drug-related deaths but there was not a corresponding increase in other harm-related behaviours such as violence, theft or physical health issues, but overall heroin use was in decline as it fell out of fashion with younger people who used drugs.

In summary, spatiality significantly shapes the experiences and behaviours of people who use drugs in their everyday practice. A reliance on public transport to navigate the expansive geography, for instance, plays a crucial role in structuring and influencing the regulation of heroin use. The absence of anonymity contributes to heightened awareness of heroin use, leading to modifications in related activities and behaviours such as theft, to ensure ongoing community acceptance. Factors like controlled and regulated drug use, community inclusion, stable housing, free and accessible healthcare, and ongoing support through benefits and methadone ensure that participants do not view their drug use as problematic. These factors also shape their perspectives and engagement with recovery. I contend that the unique impact of rurality on people using heroin necessitates specific consideration in the development of recovery strategies and policies. Recovery services must be aware of and be prepared for new drug-using behaviours in a once-stable population of people with substance use disorders and the potential impact and consequences this may have. They also need to modify their working parameters and practices to meet the needs of their rural clientele if they wish to engage them in recovery pathways. The subsequent section explores the impact of addiction and recovery within the context of my findings.

9.2.2 Addiction and Recovery: identity, recovery capital and everyday life.

Drawing from recovery literature, including studies by Biernacki (1986), Granfield and Cloud (2001), Gryczynski et al. (2009), and Neale et al. (2012), and based on the 2008, *The Road to Recovery* strategy I had naively assumed that abstinence would be the primary focus for individuals using heroin and the recovery services they engaged with. However, from the earliest stages of my research, it became very apparent that this was not the case. I came to realise that recovery is far more complex than a single concept with a rigid application. It became evident that recovery, contrary to political strategies, media portrayals, and societal beliefs, is nuanced, individualised, and flexible. The concept of recovery proved to be so intricate and personalised that even healthcare professionals at the SDAS, responsible for its application, were uncertain of its parameters and meaning. Recovery, understood only as abstinence, was not considered by my participants. However, when framed in the context of harm reduction, it appeared to positively impact their daily practices by contributing to "stability" through for instance, health checks, naloxone, sterile injecting equipment, and methadone. Scholars such as Neale at al. (2011a; 2011b) argue that such harm reduction

strategies are integral to recovery pathways. These strategies minimise everyday risks associated with heroin use while acknowledging that not all people who use heroin can or want to attain abstinence. Harm reduction strategies as discussed by Schiebe, et al. (2017) and Delargy, et al. (2019) can, however, facilitate stability and encourage small steps toward long-term improvements, empowering individuals to take control of their drug use, identities and lives. This approach reduces stigma, where harm reduction interventions and language are person-centred and normalised. Consequently, it promotes healthcare engagement, reduces blood-borne viruses, and overdose, while fostering hope that change can happen. Central to this tension between abstinence as recovery and harm reduction as recovery was the performance of addiction and "addict" identities.

Typically, recovery involves more than just reducing or changing heroin use; it also as Biernacki (1986), McIntosh and McKeganey (2002) and Radcliffe and Stevens (2008) posit, entails a significant change in identity. This transition involves moving from an "addict," "junkie," or "drug user" identity to becoming drug-free. The change reflects a continuum: from "I am a heroin user" to "I was a heroin user" to "I am now drug-free, recovered, and a roofer or farmer," for instance. This transformation represents a shift from a "spoiled" to an "unspoiled" identity, aligning with societal expectations of recovery, which White (1998) and Laudet and White (2010) associate with freedom from illness, improved public health, reduced criminality, and decreased economic burden. There was little evidence that recovery services or the broader community expected my participants to change their identities. However, immediate family members of Dan and Billy expressed a desire for them to stop using drugs. Most participants rejected the "addict" identity and the addiction label, aligning with scholars such as Peele, (1985), White, (1998) and Lewis, (2016), as they simply did not problematise their drug use. For them, the "addict" identity and addiction label were not, as White (1998) and Best et al. (2012) suggested, a means to understanding themselves and a platform to recovery. Instead, they viewed these labels as strategic tools that provided access to money and recovery-oriented resources. and protection against withdrawal symptoms. Adopting and performing a temporary "addict" identity was integral to accessing benefits and services. This identity was strategically employed in formal agency interactions, where participants assumed roles like actors, embellishing and exaggerating addiction-related behaviours to secure resources from SDAS (methadone and drug-using equipment) and state benefits (housing and Employment and Support Allowance). Participants shared advice on tactics and behaviours to ensure continued access to these resources, then reverted to their

pre-role state after the interview or assessment. SDAS reinforced these behaviours by applying a diagnosis of addiction, often without assessment or criteria, thus opening the gateway to benefits, recovery resources, and forms of social acceptance. Beyond serving as a gateway to benefits and services, an “addict” identity or addiction label held no discernible meaning for my participants.

My findings, aligning with urban studies by Nettleton et al. (2012) and Neale et al. (2015), highlight the importance of self-identification and recognition for participants in ways akin to those people who do not use drugs within their communities, to feel and be acknowledged as "normal." This encompassed inclusion, experiencing belonging, acceptance, and maintaining bonds with family and friends within their communities. As with Smith’s (2014) study, my participants desired to remain in their rural communities. To achieve this, they identified as being the same as everyone else within their communities who did not use drugs and reflected behaviours and practices to reinforce “normal” identity. Participants emphasised that they *were* "normal," highlighting their conventional, productive, and fulfilling lives as partners, parents and employees, all of which were maintained alongside their drug use. They rejected the notion of a “spoiled identity,” and stigmatising labels such as "addicts" or "junkies," despite their ongoing drug use. They did not seek to change their identities; they unlike Biernacki’s (1986), Keene’s, (1997), McIntosh and McKeganey’s (2002) and Hill and Leeming’s (2014) participants, had no reason to do so. The rural environment provided the means and opportunities (recovery capital) for them to maintain identities beyond spoiled ones, leaving them with no spoiled identity to recover from. Paradoxically, the lack of anonymity in their communities often bolstered and maintained their ability to be seen as both an “addict” and not an “addict” a concept previously explored by Peele (1985).

The necessity for an "addict" identity and addiction label is perpetuated by formal agencies like the NHS and the U.K. Department of Work and Pensions (DWP), which categorise people. Taylor et al. (1973) and Foucault (1975), both explain that institutional frameworks and policies shape the identities and experiences of individuals who use drugs which was reflected in my findings. The NHS, grounded in the medical model, relies on diagnostics to determine treatment pathways. People in my study selectively used an “addict” identity and addiction label, a phenomenon routinely demonstrated in my findings. However, this behaviour is implausible if addiction stems solely from physiological or pharmaceutical

dependency, where addiction cannot be "performed." Framed as a "disease," addiction lacks a pathogen and cannot be measured or objectively evaluated through medical tests, unlike other diseases (Peele, 1985 and Lewis, 2016). Conversely, the DWP categorises people to meet eligibility criteria, program design imperatives, and policy specifications for disbursing benefits. Diagnostic labels are key to accessing and optimising eligibility criteria and function as gateways to essential benefits and resources, which promote recovery pathways and reduce drug-associated harms. This highlights the pivotal role labels play in constructing individuals and their trajectories within these institutions. Self-identifying as "addicts" and performing this role enables people who use heroin to access resources, whereas those who reject an "addict" identity deny themselves treatment, recovery options, and resources (Corrigan et al., 2016). Thus, the services underpinning recovery reinforce identities and labels commonly associated with stigmatisation and stereotypes, such as addiction and “addict” potentially dissuading people with substance use disorders from engaging with them.

Embracing and being able to "perform" an "addict" identity challenges the validity of many addiction models and recovery concepts, such as the medical-oriented and pharmaceutical models, while reinforcing the idea of addiction as a social construct. Analysis of my data supports the view that addiction, as described by scholars like Becker (1964), Lindesmith (1968), Peele (1985), Stephens (1991), Davies (1993), Bourgois (1995), Weinberg (2002), and Reith (2004), is a social construct. In this perspective, addiction and an "addict" identity are seen as social roles produced and performed through interactions and negotiations between individuals, rather than as inherent or objective realities. Scholars of recovery, as previously identified, argue that shifting away from an "addict" identity is essential for recovery and its continuation. However, their analysis often overlooks the strategic "performance" of identity. My participants found such performances necessary to fulfil their roles and attain recovery capital because they did not see themselves, nor were they seen by their communities, as "addicts." The material conditions of their rural lives, close-knit communities, long-standing relationships, family ties, and a lack of anonymity, afforded them the means to maintain other identities. They identified as friends, partners, employees, and neighbours, living and portraying "normal" lives without spoiled identities to recover from, which fundamentally contrasts findings from studies by Biernacki (1986), McIntosh and McKeganey (2002) and Radcliffe and Stevens (2008). Their drug use, although generally controlled and regulated, continued and was inadvertently sustained by the very recovery

capital intended to promote recovery. This recovery capital and their accepted identity provided stability to their everyday lives and practices, supported by the DWP and SDAS, which provided monies, methadone, naloxone kits, health assessments, and care. Stability in participants everyday was evident through regulated drug use, stable housing, low incidence of violence and theft, and ongoing consistent engagement with SDAS.

I found recovery often begins at some intersection with change, manifesting through shifts in identity and everyday practices and embodiment. Scholars like Biernacki (1986), Laudet et al. (2009), Nettleton et al. (2011), McIntosh and McKeganey (2013), and Kemp (2013), suggest that such shifts can be catalysed by various factors, including reaching a personal nadir, making a rational decision to change, or experiencing disillusionment with the drug lifestyle and milieu. Alternatively, change may emerge from recovery capital, which, as noted by Granfield and Cloud (2001), Laudet and White (2008), Hennessy (2017), and Groshkova et al. (2013), provides a foundation for transformation and resilience, which my participants all had access to.

Fredrickson and Joiner (2002), Crossley (2007), Weinstock, et al. (2008), Nettleton, et al. (2011), Neale, et al. (2012), and Petteway (2019), propose that change can also occur through transformations in everyday practices and embodiment, such as pregnancy, aging, imprisonment, or relocation. Each of these avenues involves diverse actors wielding varying degrees of agency and holding distinct perspectives on recovery and abstinence. Recovery denotes a change of a drug-centred existence into a "better life," sometimes culminating in abstinence. Attaining abstinence signifies a profound change from the identity of an "addict" to that of a non-addict, supported by recovery capital and shaping the individual's everyday life. However, my research revealed that my participants perceived themselves as possessing "normal identities", despite being subject to everyday practices and embodiments associated with drug use noted previously. Paradoxically, despite the abundance and accessibility of recovery capital, its presence often perpetuated “recovery inertia”, because it was construed as “negative recovery capital”. Consequently, participants deemed themselves “normal” within their everyday lives, resulting in ongoing substance use with tacit acceptance and reinforcement from their communities.

Performing addiction in contexts of relative stability brings new insight into the concept of "recovery capital." Granfield and Cloud (2001), Laudet and White (2008), Groshkova et al. (2013), and Hennessy (2017), highlight that recovery capital represents the resources a person has that enables change in drug-using behaviours, activities, and attitudes. For those who have it, drawing on this capital can facilitate making and sustaining change in everyday practices, thereby reducing drug use and associated harm. For my participants, recovery capital took many forms, such as state benefits, housing, familial and community support, and friendships which provided them with economic and social capital. However, accessing some of these resources required participants to "jump" through prerequisite "hoops," and crucially perform low recovery capital and an "addict" identity. Cloud and Granfield (2008) identified "negative recovery capital" as barriers and challenges that obstruct recovery efforts and deplete the resources needed for successful recovery. These factors include stigma, poverty, discrimination, lack of access to healthcare, lack of social support services, isolation, unemployment, homelessness, mental health disorders, low self-efficacy, and lack of motivation.

My findings extend their concept to include "stability and security". Stability and security are typically considered foundational factors for rebuilding lives and sustaining long-term recovery, as noted by Cloud and Granfield (2008), Kelly and White (2011), and Best (2012). However, I found that these factors, along with self-efficacy, inclusion, access to healthcare and social support services, connections, and stable housing, were paradoxically situated as "negative recovery capital" in my study. They did not contribute to recovery pathways as suggested by Cloud and Granfield (2008), Laudet and White (2008) and Best and Laudet (2010), they did contribute to "recovery inertia" by impeding progress toward changing drug use behaviours and recovery pathways. My findings suggest that the current perspectives on recovery capital need careful consideration to better support recovery efforts. Nonetheless, participants' lives did sometimes change, albeit in small ways, perhaps leading to a "better life." This was reflected in interactions with SDAS and stabilisation of their lives through methadone maintenance programmes, state benefits and regulated substance use. These measures allowed participants to integrate with their communities while continuing their drug use, thereby avoiding typical income generation methods and behaviours negatively associated with drug use, such as public drug use, theft and violence.

SDAS viewed this as a positive step toward recovery, as it reduced potential harms such as overdose and health related issues. Participants felt it was necessary to ensure ongoing access to resources and "performed" accordingly. People who did not use drugs within their communities were generally accepting of participants' drug associated lifestyles, if they did not impact their own or their families' lives. This situation had benefits, but it also maintained the status quo. Recovery capital, as found by Granfield and Cloud (2001), Cloud and Granfield (2008) and Best, et al. (2016) often turned into "negative recovery capital." This meant participants felt content and secure continuing their drug and methadone use and were not motivated to transition from their drug-using lives to recovery pathways, such as legitimate employment and abstinence. Their drug-using lives became "normal," mundane lives because as Foucault (1967; 1994) alludes life *is* mundane, despite their ongoing drug use. Yet, their everyday practices and the interventions promoted change towards a "stable life," even though these changes were often small, subtle and nuanced, for instance carrying naloxone, regulating their drug use, socialising and continuing with daily scripts for methadone.

The continuous requirement to perform an "addict" identity required to secure recovery capital necessary to enable fundamental changes envisioned in all theorisations of recovery, places my participants in a complex position. This lies at the heart of "recovery inertia": the very recovery capital that supports and promotes recovery such as friends, family, and housing, becomes "negative recovery capital" by providing security. The identity performances required to access harm reduction/recovery resources, such as friendly drug workers, methadone, and injecting equipment, necessitate a performance of a spoiled identity, undermining attempts to develop "non-addict" identities, which Biernacki (1986) posits as crucial for recovery. Simultaneously, the acceptance of an "addict" identity among neighbours, friends, and families provides social capital and social well-being, which then act as barriers to achieving abstinence-based recovery. This may also diminish individuals' motivation to pursue change or significantly alter their drug-using behaviours, consequently perpetuating their drug use as their lives become "stabilised" and "recovery inertia" is realised. This situation presents a clear paradox: while recovery capital is intended to reduce drug use, stabilise everyday life and practices, and challenge drug-using identities, it simultaneously facilitates and enables ongoing drug use and associated behaviours, creating "negative recovery capital" as highlighted by Cloud and Granfield (2008), and a "catch-22" scenario by unintentionally cementing "recovery inertia". Furthermore, the extent of "recovery capital" for those who did not engage with SDAS remains uncertain.

The research conducted by scholars such as McIntosh and McKeganey (2000; 2001; 2002), White (1998; 2007), Neale et al. (2012), and Nettleton et al. (2012), has focused on individuals in recovery or those who have recovered from drug addiction. During their addiction, these studies have highlighted that every day, mundane activities were often neglected in favour of cash generation, acquiring drugs, and maintaining associated lifestyles, which became full-time preoccupations. Their findings indicate that during recovery, these individuals often had to (re)learn mundane activities, such as personal hygiene, housework, paying bills, timekeeping, employment, and social interactions. When drug use ceased, researchers like White (1998) and Neale (2012) found these activities became essential for reintegrating as a functioning member of society and necessary to fill the void drug use left. Nettleton et al. (2012) explained that the transition from addiction to recovery varied for everyone, with each person demonstrating strengths and weaknesses in related areas. For example, shoplifters needed to appear like regular shoppers to avoid drawing attention to their "addict identities" from security. Sex workers had to maintain their appearance to continue attracting clients. Parents had to demonstrate their parental capabilities to avoid losing custody of their children. Fundamentally, as noted by Best (2019), individuals in recovery must reorient themselves back into mainstream society, drawing on their strengths or addressing their weaknesses to ensure integration into a society that may not readily welcome them due to their past behaviours.

Heroin and methadone were part of and were integrated into the everyday practices of my participants, but contrary to narratives by scholars such as Pearson (1987), Stephens (1991) and Alexander (2001), Neale, et al. (2009) and McLellan (2017), they did not consume or dominate their entire existence. While these substances were accessible, participants were cautious to avoid actions or behaviours that could disrupt their access. They made efforts to change and adapt negative behaviours commonly associated with drug use to ensure acceptance and tolerance within their communities, demonstrating that such adaptations were possible even while using illicit drugs. Adaptations included regulated drug use, maintaining social interactions, discreet consumption, and nonviolent behaviour. These strategies, supported by interventions from SDAS, contributed to "stabilising" their lives and substance use. However, these behaviours were not seen as stepping stones toward recovery pathways; rather, they simply maintained a sense of normalcy. Moreover, participants aimed to minimise changes in their lives, as they already perceived their lives to be "good lives". Nevertheless, my findings reveal that participants were integrated into their rural

communities and managed everyday aspects of life alongside heroin use, using recovery capital to ensure this. The rural setting also provided facilities to support this practice, many of which might initially be considered negative by scholars, such as Neale et al. (2012) and Nettleton et al. (2012). A lack of anonymity in small, closely-knit communities meant that relationships were often well-established before drug use began and continued when participants developed substance use disorders. Commuting on public transport, a necessity for traveling throughout the region, required participants to be functional and alert. State benefits and access to heroin reduced the urgency for cash generation and acquiring drugs, making participants "time rich."

My participants utilised the rural facilities and available time to engage in “normal” everyday activities, such as attending health appointments, maintaining personal hygiene, shopping, cleaning, and working. This engagement promoted their well-being, integration and helped regulate their drug use, aligning with Nettleton et al. (2012) and Neale et al. (2015) findings. As a result, their relationships with friends, family, and the community improved, reducing social stigma. They maintained their identities as friends, parents, and employees, rather than solely as “addicts.” They continued to draw on recovery capital, while using drugs and methadone, because their drug use was not problematised. They led stable lives, with homes, social relationships, and controlled drug use. This stability enhanced their status within their communities, promoting their acceptance as 'normal' citizens. Consequently, they did not feel the need to change their identities or drug use, and mainstream society largely accepted them and their lifestyles without prejudice, provided their drug use and associated behaviours were controlled and regulated. Their unspoiled identities, “negative recovery capital” and everyday integration played a pivotal role in maintaining their “recovery inertia”.

I found mundane everyday practices took precedence for many participants, just as they do for people who do not use drugs. Tasks such as caring for others, housework, personal appearance, socialising, shopping, and cash generation were routinely prioritised and shaped their identities. By engaging in these everyday practices, participants speak to recovery by completing these arguably mundane tasks and demonstrating as Biernacki (1986) and Dahl (2015) found, recovery goes beyond reducing heroin use, changing an identity and abstinence. Although cash generation and acquiring drugs were necessary, these tasks did not dominate their everyday lives, recovery capital as Cloud and Granfield (2008) note, plays a pivotal role in such scenarios. Heroin and other drugs were often considered "functionally

important" to prevent withdrawal symptoms and enable individuals to “function” and be “normal” at an everyday level. In many ways, participants’ everyday practices were indicative of and reflected “stability” not chaos often identified with heroin use (Tweed and Rodgers 2016). However, like people who did not use drugs, their lives were subject to change due to various intrinsic and extrinsic factors.

Recovery is arguably, a moment linked to substances, a dynamic process changing relationships with heroin. This change can range from transitioning from drug use to abstinence, from heroin use to methadone maintenance, or from injecting to smoking, all aimed at enhancing quality of life or, at the very least, preventing its decline. My research indicates that recovery extends beyond abstinence, harm reduction, identity, recovery capital, and everyday practices. It represents a transformative journey intrinsically linked to heroin use and a dynamic and holistic process that encompasses evolving relationships with it. Recovery as Biernacki (1986), Cloud and Granfield (2008), Neal et al. (2011a) and Nettleton et al. (2012) suggest, symbolises a departure from detrimental practices, embracing various social, personal, and behavioural changes. These include transitioning from unemployment to employment, forming drug-free relationships, shifting from harmful to less harmful activities, transforming one's identity from a "spoiled" to an "unspoiled" state, addressing physical illness to achieve wellness, tackling psychological challenges, and seeking spiritual fulfilment beyond drug use. Ultimately, recovery is synonymous with "change", which is *the* common denominator through all aspects of the recovery journey.

The complexity of recovery as noted by Davies (1993), Reith (2004) and Reinarman (2005), presents challenging and sometimes unattainable expectations for individuals with heroin addiction, as well as for recovery services tasked with policy implementation. Motivation for change may be lacking, or individuals may undergo changes in difficult, unexpected ways. Surprisingly, the cessation of drug use or the pursuit of a "better life" were not primary motivations for change among my participants. They did not prioritise or value these goals over recovery principles or expectations set by others. In fact, for many participants, stopping drug use often made them feel worse, not better. Withdrawal symptoms, feelings of isolation, and shifts in identity left them feeling uncertain about their sense of self, while the time previously spent engaged with drugs was replaced with feelings of boredom. My participants were content with their lives and saw little need for change. They found fulfilment in their current circumstances and did not believe that abstinence, despite its removal of drug-related

harm indicators, would significantly enhance their well-being as they were already living their best lives.

My findings highlight that my participants regulated and controlled their drug use without the need for intervention from recovery services, aligning with Biernacki's (1986) findings. However, unlike Biernacki's participants, who experienced "natural recovery" and "change" gradually reducing their substance use over time, the participants I encountered experienced and exhibited what I term "recovery inertia." This concept encapsulates a "resistance to change" that reinforces and perpetuates existing patterns of drug use, hindering pathways toward personal transformation and recovery. Recovery inertia represents a novel two-fold concept, grounded in the core understanding of "change" in recovery as previously identified. This encompasses movement towards controlled use (UKDPC, 2008), abstinence (Scottish Government, 2008; Betty Ford Institute, 2007), changes in identity (Biernacki, 1986; McIntosh and McKeganey, 2002), and changes in everyday life and bodily practices (Neale et al., 2012). This was a group of people who, as individuals, as members of a community of people who use heroin, and as members of the communities in which they lived, worked and had families, did not actively seek to change their lives or their heroin use. When encouraged to pursue change by SDAS, they largely resisted. Thus, they were characterised by an 'inertia' towards recovery. However, it's important to note that this inertia is not a *failure of recovery*; rather, it serves as a critique of viewing recovery as the sole desirable outcome of substance use.

"Recovery inertia" highlights the resistance individuals exhibit when recovery pathways are limited to abstinence and necessitate a performance of addiction to access resources. Factors contributing to "recovery inertia" among my participants included resistance to and fear of change, loss of hope, entrenched practices and beliefs, interconnectedness with the drug-using community, a lack of urgency for change both from individuals and recovery-associated institutions and services, ambivalence, not problematising their heroin use, and contentment with their current lifestyles and practices. "Recovery inertia" speaks to the underlying dynamics that can inhibit people who use heroin from exploring, engaging in, and accepting change, or understanding change solely as reducing substance use. "Recovery inertia" persists unaffected by identity, recovery capital, or everyday life and embodied practices, even when these are perceived as challenging or detrimental. "Recovery inertia"

offers a way of thinking about change more broadly, moving away from measurable substance-use outcomes and toward person-centred approaches. This aligns with the "New Recovery" paradigms proposed by Best et al. (2016b) and Winship (2016). Overcoming “recovery inertia” requires holistic, inclusive, equitable, and resilient strategies and approaches to encourage sustainable recovery, which may or may not necessarily entail abstinence.

“Recovery inertia” offers insights into the experiences of individuals who use heroin and find contentment in their current identities, lives and lifestyles. It identifies people who use heroin and aspire to enhance their lives without pursuing abstinence. This concept surpasses traditional recovery models by shedding light on why some people who use heroin do not actively pursue abstinence or significant changes in their heroin use, despite being aware of its significant physical, mental, and social risks. “Recovery inertia” acknowledges that these individuals have agency, are knowledgeable about and can be responsible for their drug use and lifestyle choices. It recognises that subtle influences from societal expectations, education, or personal beliefs can lead to nuanced changes in their drug use, thereby mitigating potential negative impact while they continue to use drugs. This process may persist indefinitely or until they opt to engage with a recovery pathway that aligns with their needs and preferences at a suitable time.

In summary, the exploration of addiction within the framework of my participants' daily practices and self-identities reveals it to be a socially constructed concept. This was underpinned by participants adjusting their behaviours and personas to “perform” addiction and enact an “addict” identity based on their preconceived ideas of how an “addict” should act, and what their peers explained was necessary to access resources from recovery services and government agencies. Recovery, as observed in the study, was nuanced, with no single concept more prominent or dominant than another. Participants routinely rejected abstinence-based pathways, engaging with recovery services primarily for the resources they offered. However, a common thread across the various recovery frameworks was the theme of "change." This change was intricate and nuanced, but often noted in identities, recovery capital, “negative recovery capital”, harm reduction, and abstinence. Recovery was evident in these transformative processes. Crucially, the provision of stability was a cornerstone of recovery services, aimed at mitigating the harmful consequences of substance use, even in the absence

of complete abstinence. Despite these efforts, the phenomenon of "recovery inertia" became evident in participants' behaviours, where resistance and entrenched patterns contributed to sustained drug and methadone use. The following section will critically evaluate the strengths and limitations inherent in the study's methodology and findings.

9.3 Study strengths and limitations.

This study offers a unique insight into the everyday practices, realities and world views of 51 people who use heroin in a rural region of Scotland, along with unexpected insights from 20 of their recovery service providers. The ethnographic methodology employed, and associated methods are transferable, and my successful application of these methods may inspire other researchers to explore similar groups often considered a “difficult to reach” population.

My participants provide valuable insights into heroin use, recovery and the experiences of people who use heroin in a rural setting in Scotland, a country where drug-related deaths are among the highest globally, amidst a prevalent culture of drug use. By engaging with my participants, I gained a first-hand understanding of their everyday practices and realities, exploring rural perspectives often overlooked in heroin use and recovery narratives, which tend to focus on urban settings. Their voices and experiences offer a unique insight into heroin use and recovery in rural settings, providing an authentic portrayal derived from their lived experiences. Throughout my observations and interactions with them, I explored the nuances and intricacies of their lives as they navigated their drug use and recovery within their rural communities, uncovering the unique challenges and opportunities they encountered. While each participant's journey was personal and unique, collectively, their narratives reveal common threads and themes that shape their experiences. This offers an original contribution and insight to the broader discourse on addiction and recovery. My participants represented a homogenous group reflecting the demographics of their communities and region as a whole: primarily older, single, unemployed Caucasian men who administered heroin intravenously, alongside other substances including prescription methadone and alcohol.

I discovered that people who use heroin within the region tended to be older with extensive histories of drug use. However, there was a noticeable decline in heroin use among younger people, who favoured street benzodiazepines, recreational drugs, and alcohol, citing they were

as effective as heroin, more cost-effective and fashionable. An interesting shift was observed among older people who previously used heroin exclusively but now reported incorporating methadone, street benzodiazepines, and alcohol into their drug use routines. Participants commonly reported that they believed heroin to be low purity, but they explained it was affordable, readily available and accessible throughout Dumfries and Galloway. The purity of these drugs remained uncertain, raising the potential for unintentional overdose. Both participants and SDAS staff believed these factors contributed to the increase in drug-related deaths within the region.

Despite limited recovery services, statistical data suggested that drug use rates in Dumfries and Galloway were comparable to other regions in Scotland, with lower drug-related deaths per capita than many other regions. Participants did not typically problematise their drug use, which was evident in their ambivalence to recovery and local recovery services. Recovery pathways in Dumfries and Galloway diverged from a traditional abstinence model, which was roundly rejected by participants. Instead, they engaged with harm reduction practices, receiving incentives such as free methadone or drug-related equipment to “encourage” ongoing contact with recovery services. In contrast to common assumptions about people who use heroin in urban settings, my participants routinely demonstrated regulated and controlled heroin use, even when heroin was accessible. Factors commonly associated with rural settings such as a lack of anonymity, geographical constraints, and limited transport contributed to this regulated use. Regulated and controlled heroin use mitigated unwanted scrutiny and tensions from both people who did not use drugs and the criminal justice system, subsequently reinforcing this behaviour. Participants self-identified as "drug users," rejecting stigmatising labels like "addicts" or "junkies." They consistently portrayed themselves in socially positive roles such as partners, parents, friends, and employees. This perspective encouraged them to perceive themselves as "normal" despite their history of drug use, reporting that they led conventional, fulfilling, and generally content lives within their communities. This challenges prevalent stereotypes that often link heroin use with chaotic lifestyles, public drug use, deviancy, criminality, and violence. The widely held notion of constant drug-seeking behaviours and criminal activity for cash-generation were not routinely observed among participants.

Not all people who used heroin wanted to be involved in my study and there were assorted reasons for opting out. Some did not self-identify as being dependent on heroin, others lacked motivation to engage, and some simply had no interest in me or my study, prioritising other

activities over participation, they simply had “better things to do”. Where I was afforded the opportunity to explain my research rationale and criteria, participants generally expressed an interest. Maintaining contact with those who agreed to be involved proved to be challenging for several reasons such as the geographic constraints, disinterest, and participants needing to “be somewhere else.” I was often “stood up” or “patched,” with my calls and text being ignored. Persistence proved crucial. Over time, my participants ultimately became consummate hosts, with many eager to share their experiences. This study highlights the potential for further research in this area, demonstrating that people who use heroin in rural settings can indeed be reached and engaged. Future studies can build upon this foundation to deepen our understanding of rural heroin use and its broader implications.

My philosophical perspective challenges entrenched assumptions surrounding people who use heroin, addiction and recovery, urging a deeper examination of societal labels and their implications. It advocates for a holistic understanding of people who use drugs, emphasising their complexity and the need for comprehensive person-centred support beyond conventional frameworks like harm reduction and abstinence. Contrary to prevailing beliefs, my research uncovers a shifting landscape of drug use, with heroin on the decline and polysubstance use on the rise, coinciding with increased drug-related deaths in Scotland. Despite this evolution, participants do not perceive drug use as inherently problematic, opting for regulated and controlled consumption in their everyday practice. Even amidst the persistent challenges associated with long-term heroin use, such as overdose, social stigma, health issues and drug-related deaths, participants led fulfilling lives, challenging stereotypes of chaos and dysfunction. They rejected the notion of an "addict's spoiled identity," asserting their place as valued and included members of their communities. Institutional responses were found to sometimes exacerbate rather than alleviate issues surrounding drug use, perpetuating harmful labels and restricting access to support. However, my study highlights the resilience and agency of people who navigate these barriers, forging meaningful lives despite societal misconceptions and ongoing drug use. By offering a nuanced exploration of an underrepresented community along with the challenges and opportunities rural living brings, my research enriches our understanding of drug-related issues and informs more effective policy and intervention strategies, focussed specifically on the needs of people who use heroin within rurality. It also invites urban researchers to reconsider their assumptions and explore parallels and differences in diverse contexts.

Of course, as with any research endeavour, my study has limitations. Firstly, due to full-time employment and family commitments, I could only spend limited time with my participants. Consequently, I could not fully explore every avenue or opportunity that presented itself, potentially missing valuable experiences and details in the field. A dedicated full-time researcher would have unrestricted time for comprehensive fieldwork. Secondly, there were certain activities and behaviours, such as large-scale drug trafficking from outside the region that I felt could have heightened my experience, but I was hesitant to investigate due to its associated criminality. While I engaged in participants' everyday practices to the best of my ability, there were aspects I expected to observe, like rough sleeping and outdoor drug use, commonly observed in urban areas that were not prevalent in my study area. Thirdly, my one-year duration in the field limited the depth of my findings. More time spent within the community would have facilitated greater trust and insight. Fourthly, the geographical boundaries of my study area restricted travel to other areas, such as cities, where participants travelled to procure drugs. Exploring these experiences could have provided additional valuable data. Fifthly, as a registered nurse bound by strict ethical codes of practice, I was obligated to report concerns about child welfare, which curtailed access to people who used heroin with children, thereby denying them a voice. Researchers without such constraints may have better access to this marginalised group and provide much needed insight into their worlds. Sixthly, recruitment was dependent on engagement with the SDAS, meaning there were people who used heroin who did not access recovery services and thus were not included in my study. Finally, being a male researcher limited my access to women with substance use experience. A female researcher may have more opportunity to engage with and gather information from women who use drugs accessing information I could not.

9.4 Further research considerations.

People who use heroin in rural settings *are* accessible to researchers and encounter many similar challenges to those in urban settings. They also face unique circumstances and opportunities due to the spatiality of their rural environment. Particularly, rural mothers who use heroin warrant further investigation. My research encountered difficulties in locating and recruiting such women, specifically those with children. Those I did manage to communicate with expressed fear of losing custody of their children if they engaged with the region’s recovery services or participated in my research. This reluctance stemmed from a well-founded fear of potential repercussions, including the possibility of their children being forcibly

removed if their heroin use was disclosed. This concern was consistently highlighted in my findings. It is important to recognise that heroin use does not inherently make someone a "bad mother" or unfit parent. In fact, they may benefit the most from recovery services, as children can represent significant motivation and "recovery capital" to them (Taylor, 1994; Ettore, 1992). Despite this potential benefit, mothers were found to be the least likely group to engage with recovery services, presenting yet another paradoxical situation.

Given the findings of this research, which challenges common perceptions and demonstrates that people can lead "normal" lives despite heroin use and its associated risks, further investigation into the experiences of rural mothers who use heroin is imperative for them and their children. Understanding their unique challenges and needs can inform the development of tailored rural recovery services. It is crucial to explore their specific circumstances to ensure their needs are addressed in future drug strategies. However, it is important to acknowledge that the welfare of children takes precedence over all other considerations. This priority poses significant challenges for mothers who use heroin, as well as recovery services, child protection agencies, and researchers. There is a compelling need for recovery-focussed interventions and strategies tailored to the specific needs and complexities of these women's lives. Addressing these pervasive factors is essential to mitigate drug use, foster engagement with recovery services, and engender meaningful change in their drug careers, thereby contributing to resolving Scotland's national drugs crisis.

There were multiple accounts from both participants and SDAS staff indicating the presence of people who used heroin but were not registered with or known to recovery services in the region. Their exact nature is unknown, and their numbers were indeterminate. Nonetheless, they constitute a marginalised community whose experiences warrant attention and could offer further valuable insights into drug use in rural areas. Another avenue for further research involves examining the perspective of people who do not use heroin in rural settings. Throughout my data collection, I encountered numerous instances of unexpected kindness and compassion demonstrated by community members toward those known to use heroin. This phenomenon extended beyond groups of people who had grown up together to reported interactions with local police officers. The factors contributing to this acceptance and inclusion within the broader community, as well as its implications for heroin use and those people who use it, warrant thorough exploration and investigation.

9.5 Recommendations for services.

My study provided an opportunity to offer recommendations for local recovery services within my study area, and potentially for those further afield. As previously discussed, despite limited recovery services, the SDAS recorded one-third fewer deaths per capita in Dumfries and Galloway compared to many urban areas in Scotland. Therefore, my observations and recommendations are highly relevant. Participants consistently expressed that the concept of recovery as abstinence was meaningless to them; they did not want to stop using heroin. Perhaps as a result, SDAS staff emphasised a harm reduction approach, focusing on preventing drug-related deaths rather than pursuing and insisting on abstinence. It is time for recovery efforts to operationalise a focus on specific harm reduction interventions beyond those currently used by their service users, such as methadone and sterile equipment.

I believe the need for consultation with both those who are registered and those who are not registered with SDAS is essential for the collaborative and ongoing identification and development of harm reduction interventions which are specific to the region. These interventions should include establishing female-only clinics with specific harm reduction interventions designed for women and mothers who use heroin. Additionally, consideration should be given to the location and delivery methods of interventions, taking into account the rural nature of the area. This might involve emphasising the role of outreach workers or implementing mobile services with access to a safe consumption area.

Understanding the influence of public transport on heroin-associated behaviours could be enhanced by extending the operating hours of recovery services to include weekends and evenings and aligning them with bus timetables. Establishing open clinics, whether face-to-face or digital, would allow people who use heroin and their families to access support and advice at their convenience and without appointments. Providing instant access to residential rehabilitation facilities would ensure that spontaneous recovery opportunities can be acted upon immediately. Pharmacists could also extend their operating hours and offer private rooms as standard to ensure privacy for discreet methadone administration. Recovery services could also provide weekly methadone prescriptions, explore the provision of pharmaceutical benzodiazepines, and potentially establish heroin consumption rooms with healthcare professionals present.

9.6 Final thoughts….

My sincere hope is that this thesis does not merely gather dust on a shelf or serve solely as a conduit to an academic accolade. Instead, I aspire for it to stand as a testament to the lives (and deaths) of the people who use heroin in Dumfries and Galloway, whom I had the privilege to encounter. I aim for it to provide a voice to a voiceless community. I hope too that I have given you, the reader, an insight into their worlds. My final thoughts reflect findings which identified my participants as parents, friends, partners, neighbours and family members, who just happened to use heroin. They led largely conventional, fulfilling, and inclusive lives within their communities, experiencing everyday issues, some drug-related and some not. Despite facing significant challenges related to illicit drug use and living in a rural setting such as dependency, health issues, violence, scrutiny from social services and the criminal justice system, poor transport, expansive geography, overdose, and death, they still found meaning and purpose in their lives. Heroin use, driven by various and sometimes no reasons, was not problematised; it was integrated into their lives and often helped them to "function" within society and attain their “normal.”

While heroin was a significant aspect of their daily practices, it did not dominate their lives, nor did the concepts of "addiction" or "recovery." They did not reflect a “spoiled identity” and consequently did not self-identify as "addicts.” Instead, they used the identity and label of “addiction" both of which were routinely “performed” to meet the requirements set by agencies to access services and state benefits. This led me to reconsider addiction as a concept, which my nurse training had embedded within the medical model and reposition it as a social construct. For my participants, recovery did <u>not</u> align with conventional notions of "recovery strategies," pathways, or the pursuit of abstinence. Recovery capital, available and free, became “negative recovery capital,” providing stability and giving rise to my concept of “recovery inertia.” Recovery then, was not considered in a traditional sense. However, recovery was evident in my participants’ lives in a nuanced way, prompting me to reconceptualise it as ongoing “change.” *The Road to Recovery* strategy, which I applied throughout my study, advocated for people to become "active and contributing members of society." My findings routinely reflected that my participants embodied this role in tandem with their heroin use. Thus, the concept of recovery as "a process through which an individual is enabled to move on

from their problem drug use towards a drug-free life" was not applicable; heroin use was simply not problematised and was mostly controlled and regulated.

People who used heroin did, as *The Road to Recovery* strategy states, pose a danger to themselves by using illicit drugs of unknown strength, sometimes using alone and in isolated environments where phone signals and transport were poor. Nonetheless, participants desired the freedom to use heroin, and did so within the unwritten boundaries set by their communities. In a broader context, addiction and recovery from heroin use hold significant importance for policymakers, strategists and certain sectors of society. However, there is a clear disconnect between policymakers and the lived experiences of those who use heroin. A paradigm shift is needed to challenge societal assumptions about heroin and illicit drug use, focusing on promoting tolerance, education, social acceptance, decriminalisation, and potentially deregulation in future policies and strategies. My thesis stands as a testament to the resilience and complexity of people who use heroin. By challenging stereotypes and highlighting their integration within communities, it demonstrates how positive societal views, compassionate approaches, and inclusion can effectively support them. Adoption of these factors could promote recovery and positively impact Scotland’s unenviable relationship with illicit drugs and the associated harms and deaths.

References

Abbot, A. (1997). Of Time and Space: The Contemporary Relevance of the Chicago School. Social Forces; 75(4) pp1149-1182.

Adler, P. (1992). Wheeling and Dealing: An Ethnography of an Upper-Level Dealing and Smuggling Community. Columbia University Press, New York.

Adler, P., Adler, P. and O'Brien, P. (eds.). (2012). Drugs and the American Dream: An Anthology. Wiley-Blackwell, New York.

Adler, P., Adler, P. and Fontana, A. (1987). Everyday Life Sociology. Annual Review of Sociology; 13 pp217-2345.

Agar, M. (1973). Ripping and Running: A Formal Ethnography of Heroin Addicts. New York, Seminar Press.

Agar, M. (1980). Getting Better Quality Stuff: Methodological Competition in an Interdisciplinary Niche. Journal of Contemporary Ethnography; 9(1) pp34-50.

Agnew, J. and Livingstone, D. (2011). Handbook of Geographical Knowledge. SAGE, London.

Ahmed, K. A. and Yusuf, C. (2004). Socio-Demographic Profiles and Treatment Outcomes of Methamphetamine Abusers in Rural and Urban Areas. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration; 28(06) pp35-49.

Alcoholic Anonymous. (2020). Alcoholics Anonymous: The Big Book. Alcoholics Anonymous World Services, New York.

Alexander, B. K. (2011). Addiction: The Urgent Need for a Paradigm Shift. Substance Use and Misuse; 47(13-14) pp1475-1482.

Alexander, B. K. (1982). James M. Barrie and the Expanding Definition of Addiction. Journal of Drug Issues; 11 pp77–91.

Alexander, B. K. (2010). The Globalization of Addiction: A Study in Poverty of the Spirit. Oxford University Press, Oxford.

Alexander, B. K. (2001). The Roots of Addiction in Free Market Society. Canadian Centre for Policy Alternatives, Vancouver.

Allan, G. and Skinner, C. (1991). Handbook for Research Students in the Social Sciences. Routledge Falmer, London.

Allen, C. and Alberici, A. (2018). "Once a Junkie, Always a Junkie": A Narrative Analysis of Cinematic Representations of the Attribution of Criminality and Deviancy to Heroin Users. (Preprint: Sourced from Reseachgate.net.).

Allen, J. (2008). The Secret Disease of Addiction: A Dis-ease Which Tells Us It Isn't One. Affinity Lodge, London.

Aluned, S.H. and Hussain, M. (1984). Heroin at Panjgur. Journal of Pakistan Medical Association; 34(2) pp31-32.

Ambrose, D. (2014). A Critique of Creativity and Complexity. Sense Publishers, Rotterdam.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorder, fifth edition (DSM V). Washington D.C.

Anderson, E. and McNair, L. (2018). Ethical Issues in Research Involving Participants with Opioid Use Disorder. Therapeutic Innovation & Regulatory Science; 52(3) pp280-284.

Angrosino, M. (2007). Doing Ethnographic and Observational Research. SAGE, London.

Annells, M. (1996). Grounded Theory Method: Philosophical Perspectives, Paradigm of Inquiry, and Postmodernism. Qualitative Health Research; 6 pp379–393.

Anyan, F. (2013). The Influence of Power Shifts in Data Collection and Analysis Stages: A Focus on Qualitative Research Interview. The Qualitative Report; 18(36) pp1-9.

Appalachian Regional Commission, (ARC) (2019). The Appalachian Region. {Internet} Available at: https://www.arc.gov/appalachian_region/TheAppalachianRegion.asp. (Accessed 18th January 2021).

Ardery, J. and Bishop, B. (2006). Substance Abuse in Rural and Small Town America. Reports on Rural America; 1(2) pp1-34.

Arndt, S. and Taylor, P. (2007). Commentary on "Defining and Measuring "Recovery". Journal of Substance Abuse Treatment; 33 pp275-276.

Association of Social Anthropologists of the UK and the Commonwealth (ASA) (2017). Ethical Guidelines for Good Research Practice. {Internet} Available at: https://www.theasa.org/downloads/ASA%20ethics%20guidelines%202011.pdf (Accessed 19th December 2021).

Atkinson, P. (2014). For Ethnography. SAGE Publishing, London.

Atkinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland, L. (2007). Handbook of Ethnography. SAGE Publications, Los Angeles.

Atkinson, P. and Hammersley, M. (1994). Ethnography and Participant Observation. In Denzin, N. K. and Lincoln Y. S. (eds.), Handbook of Qualitative Research (pp. 248–261). Sage Publications, London.

Ayed, N., Hough, S., Jones, J., Priebe, S. and Bird, V. (2020). Community Profiling: Exploring Homelessness Through a Social Capital Lens. European Journal of Homelessness; 15(2) pp39-65.

Bakhshani, N.M. and Hossienbor, M. (2013). A Comparative Study of Self-Regulation in Substance Dependent and Non-Dependent Individuals. Global Journal of Health Science; 5(6) pp40-45.

Ball, S.J. (1993). What Is Policy? Texts, Trajectories and Toolboxes. Discourse: Studies in the Cultural Politics of Education; 13(2) pp10-17.

Bancroft, A. (2009). Drugs, Intoxication and Society. Polity Press, London.

Barnard, M. and Forsyth, A.J.M. (1998). Drug Use Among Schoolchildren in Rural Scotland. Addiction Research; 6(5) pp421-434.

Bartlett, R. (2016). Idling in Mao's Shadow: Heroin Addiction and the Contested Therapeutic Value of Socialist Traditions of Laboring. Culture, Medicine and Psychiatry; 42 pp49–68.

Bathish, R., Best, D. Savic, M., Beckwith, M., Mackenzie, J. and Lubman, D. (2017). "Is it Me or Should My Friends Take the Credit?" The Role of Social Networks and Social Identity in Recovery from Addiction. Journal of Applied Social Psychology; 47(1) pp35-46.

Beardsley, K., Wish, E.D., Fitzelle, D.B., Grady, K. and Arria, A.M. (2003). Distance Travelled to Outpatient Drug Treatment and Client Retention. Journal of Substance Abuse Treatment; 25(4) pp279-285.

Becker, H.S. (1963). Outsiders – Defining Deviance. Free Press, New York.

Becker, H.S. (1964). The Other Side. Free Press, New York.

Becker, H.S. (1999). The Chicago School, So-Called. Qualitative Sociology; 22(1) pp3-12.

Bell, J. (1997). Delivering Effective Methadone Treatment. In Ward, J., Mattick, R.P. and Hall, W. (eds.). Methadone Maintenance Treatment and Other Opioid Replacement Therapies. Harwood Academic Publishers, Amsterdam.

Bell, J. (2013). Commentary on Krupitsky et al: Refuge from the Streets--Parked on Methadone, or Seeking Shelter of a Depot? Addiction; 108(9) pp1638-9.

Bell, J. (2014). Addiction and Recovery. British Medical Journal; pp349.

Bell, J. Dru, A., Fischer, B., Levit, S. and Sarfraz, M.A. (2002). Substitution Therapy for Heroin Addiction. Substance Use and Misuse; 37(8–10) pp1149–1178.

Bell, K. and Salmon A. (2011). Good Intentions and Dangerous Assumptions: Research Ethics Committees and Illicit Drug Use Research. Research Ethics; 8(4) pp191-199.

Bell, K. and Salmon A. (2011). What Women Who Use Drugs have to Say About Ethical Research: Findings of an Exploratory Qualitative Survey. Journal of Empirical Research on Human Research Ethics; 6(4) pp84-98.

Bell, K. and Salmon, A. (2012). Good Intentions and Dangerous Assumptions: Research Ethics Committees and Illicit Drug Use Research. Research Ethics; 8(4) pp191–199.

Belleau, C., DuPont, R., Erickson, C., Flaherty, M., Galanter, M., Gold, M., Kaskutas, L., Laudet, A., McDaid, C., McLellan, A.T., Morgenstern, J., Rubin, E., Schwarzlose, J. and White, W. (2007). What is Recovery? A Working Definition from the Betty Ford Institute. Journal of Substance Abuse and Treatment; 33(3) pp221–228.

Benedikt, H., Lea, W., Patrik, R. and Vogel, M. (2018). Coercion in Substance Use Disorders: Clinical Course of Compulsory Admissions in a Swiss Psychiatric Hospital. Swiss Medical Weekly; 148 pp1-6.

Berger, P. and Luckman, T. (1966) The Social Construction of Reality. Penguin, Harmondsworth.

Bernard, H.R. (2004). Research Methods in Anthropology: Qualitative and Quantitative Approaches. Rowman and Littlefield, Lanham.

Bernstein, E., Bernstein, J., Tassiopoulos, K., Valentine, A., Heeren, T. Levenson, S., and Hingson, R. (2005). Racial and Ethnic Diversity Among a Heroin and Cocaine Using Population: Treatment System Utilization. Journal of Addictive Diseases; 24(4) pp43–63.

Berridge, V. (1980). The Making of the Rolleston Report, 1908–1926. Journal of Drug Issues; 7(28) pp10.

Berridge, V. (2013). Demons: Our Changing Attitudes to Alcohol, Tobacco, and Drugs. Oxford University Press, Oxford.

Berridge, V. and Edwards, G. (1987). Opium and the People: Opiate Use in Nineteenth Century England; Yale University Press, Connecticut.

Berry, B.J.L. (1967). Geography of Market Centers and Retail Distribution. McGraw Hill, New York.

Bertrand, A.L. (1958). Rural Sociology an Analysis of Contemporary Rural Life. McGraw, U.S.A.

Bessant, J. and Watts, R. (2007). Sociology Australia. Routledge, London.

Best, D. (2019). Pathways to Recovery and Desistance: The Role of the Social Contagion of Hope. Bristol University Press. London.

Best, D. (2016). Social Identity, Social Networks and Social Capital in Desistance and Recovery. In Robinson A. and Hamilton, P. (eds.). Moving on from Crime and Substance Use: Transforming Identities. Policy Press, Bristol.

Best, D., Rome, A., Hanning, K.A., White, W., Gossop, M. Taylor, A. and Perkins, A. (2009). Research for Recovery: A Review of the Drugs Evidence Base. Social Research; pp1-4.

Best, D. and Laudet, A. (2010). The Potential of Recovery Capital. Royal Society for the Arts, London.

Best, D., Day, E., Morgan, B., Oza, T., Copello, A. and Gossop, M. (2009). What Treatment Means in Practice: An Analysis of the Delivery of Evidence-Based Interventions in Criminal Justice Drug Treatment Services in Birmingham, England. Addiction Research & Theory; 17(6) pp678-687.

Best, D., Beckwith, M., Haslam, C., Haslam, S.A., Jetten, J., Mawson, E. and Lubman, D. (2015). Overcoming Alcohol and Other Drug Addiction as a Process of Social Identity Transition: The Social Identity Model of Recovery (SIMOR). Addiction Research and Theory; 24(2) pp111-123.

Best, D., Ghufran, S., Day, E., Ray, R. and Loaring, J. (2008). Breaking the Habit: A Retrospective Analysis of Desistance Factors Among Formerly Problematic Heroin Users. Drug and Alcohol Review; 27 pp619–24.

Best, D., Gow, J., Knox, T., Taylor, A. and White, W. (2011). Recovery from Heroin or Alcohol Dependence: A Qualitative Account of the Recovery Experience in Glasgow. Journal of Drug Issues; 41(3) pp359-378.

Best, D., Gow, J., Knox, T., Taylor, A., Groshkova, T. and White, W. (2012). Mapping the Recovery Stories of Drinkers and Drug Users in Glasgow: Quality of Life and its Associations with Measures of Recovery Capital. Drug and Alcohol Review; 31 pp334–341.

Best, D., Irving, J. and Albertson, K. (2016a). Recovery and Desistance: What the Emerging Recovery Movement in the Alcohol and Drug Area can Learn from Models of Desistance from Offending. Addiction Research and Theory; 25(1) pp1-10.

Best, D., Irving, J., Colinson, B. and Andersson, C. (2016b). Recovery Networks and Community Connections: Identifying Connection Needs and Community Linkage Opportunities in Early Recovery Populations. Alcoholism Treatment Quarterly; 35(1) pp1-14.

Betty Ford Institute Consensus Panel. (2007). What is Recovery? A Working Definition from the Betty Ford Institute. Journal of Substance Abuse Treatment; 33 pp221-228.

Bewley-Taylor, D.R. (2005). Emerging Policy Contradictions Between the United Nations Drug Control System and the Core Values of the United Nations. International Journal of Drug Policy; 16 pp423–431.

Beynon, C. M. (2009). Drug Use and Ageing: Older People Do Take Drugs! Age and Ageing; 38 pp8–10.

Biernacki, P. (1979) Junkie Work, “Hustles” and Social Status Among Heroin Addicts. Journal of Drug issues; 9(4) pp535-551.

Biernacki, P. (1986). Pathways From Heroin Addiction: Recovery Without Treatment. Temple University Press, Philadelphia.

Bishop, W. (1999). Ethnographic Writing Research Writing It Down, Writing It Up and Reading It. Heinemann, Portsmouth (U.S.A.).

Blackman, S. (2004). Chilling Out: The Cultural Politics of Substance Consumption, Youth and Drug Policy. Open University Press, Maidenhead.

Bloomqvist, J. (1999). Recovery With and Without Treatment: A Comparison of Resolutions of Alcohol and Drug Problems. Paper Presented at the International Conference on Natural History of Addictions: Recovery from Alcohol, Tobacco, and Other Drug Problems without Treatment. Les Diablerets, Switzerland, 7–12 March.

Blumberg, L. (1980). The Significance of the Alcohol Prohibitionists for the Washington Temperance Societies; With Special Reference to Paterson and Newark, New Jersey. Journals of Studies on Alcohol and Drugs; 4(11) pp37-77.

Blumer, H. (1969). Symbolic Interactionalism: Perspective and Method. Prentice-Hall, New Jersey.

Bogdan, R., and Biklen, S. K. (1997). Qualitative Research for Education. Allyn and Bacon, Massachusetts,

Boothroyd, D. (2006). Culture on Drugs: Narco-Cultural Studies of High Modernity. Manchester University Press, Manchester.

Borkman, T.J., Stunz, A. and Kaskustas, L.A. (2016). Developing an Experiential Definition of Recovery: Participatory Research with Recovering Substance Abusers from Multiple Pathways. Substance Use Misuse; 51(9) pp1116–1129.

Bourdieu, P. (1977). Outline of a Theory of Practice. Cambridge University Press, Cambridge.

Bourdieu, P. (1993). Sociology in Question. SAGE, London.

Bourdieu, P. (1989). Social Space and Symbolic Power. Sociological Theory; 7(1) pp14-25.

Bourgois, P. (1995). In Search of Respect: Selling Crack in El Barrio. Cambridge University Press, Cambridge.

Bourgois, P. (2000). Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States. Culture, Medicine and Psychiatry; 24 pp165–195.

Bourgois, P. (2003). Crack and the Political Economy of the Social Suffering. Addiction Research and Theory; 11(1) pp31-37.

Bourgois, P. and Schonberg, J. (2009). Righteous Dope fiend. University of California Press, Berkeley.

Bourgois, P. (1998). The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments. Substance Use & Misuse; 33(11) pp2323-2351.

Bowers, L. (1992). Ethnomethodology I: An Approach to Nursing Research. International Journal of Nursing Studies; 29(1) pp59-67.

Boyatzis, R.E. (1998). Transforming Qualitative Information: Thematic Analysis and Code Development. SAGE, California.

Boyd, S. (2002). Media Constructions of Illegal Drugs, Users, and Sellers: A Closer Look at Traffic. International Journal of Drug Policy; 13 pp397-407.

Braun, V. and Clarke, V. (2019). One Size fits All? What Counts as Quality Practice in (Reflexive) Thematic Analysis? Quality Research in Psychology; 18 (3) pp1-26.

Braun, V. and Clarke, V. (2019). To Saturate or Not to Saturate? Questioning Data Saturation as a Useful Concept for Thematic Analysis and Sample-size Rationales. Qualitative Research in Sport, Exercise and Health; pp1-16.

Braun, V. and Clarke, V. (2006). Using Thematic Analysis in Psychology. Qualitative Research in Psychology; 3 pp77–101.

Braun, V. and Clarke, V. (2021). Thematic Analysis: A Practical Guide. Sage Publication Limited, London.

Bredahl-Petersen, F.E. (1973). Family Organisation in Rural Iceland. PhD. Thesis, University of Edinburgh.

Brewer, J.D. (2000). Ethnography. Open University Press, Buckingham.

Briggs, D. (2012). Crack Cocaine Users: High Society and Low Life in South London. Routledge, London.

British National Formulary (2021). B.N.F. British Medical Association and Royal Pharmaceutical Society of Great Britain, London.

Brown, B.S., Voskuhl, M.S.W. and Lehman, P.E. (1977). Comparison of Drug Abuse Clients in Urban and Rural Settings. American Journal of Drug Alcohol Abuse, 4 (4) pp445-454.

Brown, M. and Bolling, K. (2007). Drugs Misuse in Scotland: Findings from the 2006 Scottish Crime and Victimisation Survey. Scottish Government, Edinburgh.

Brown, S.A. (2015). Stigma Towards Marijuana Users and Heroin Users. Journal of Psychoactive Drugs; 47, pp213–220.

Brown, A.M, McDaniel, J.M, Johnson, V.H. and Ashford, R.D. (2019). Dynamic Labeling Discernment: Contextual Importance of Self-identifiers for Individuals in Recovery. Alcohol Treat Q; 38(2) pp215–230.

Bruce, K.A. (2001). The Roots of Addiction in Free Market Society. Canadian Centre for Policy Alternatives. Vancouver.

Brunswick, A.F. (1978). Black Youth and Drug Use Behavior. Columbia University School of Public Health, New York.

Bryman, A. (2001). Ethnography: Volume 4. SAGE, London.

Bulmer, M. (1984). The Chicago School of Sociology: Institutionalization, Diversity and the Rise of Sociological Research. University of Chicago Press, Chicago.
Burchardt, J. (2015). Rethinking the Rural Idyll: The English Rural Community Movement, 1913-26. The Journal of the Social History Society; 8(1) pp73-94.

Burhan, H., Young, R., Byrne, T., Peat, R., Furlong, J., Renwick, J., Elkin, T. Oelbaum, S. and Walker, R.P. (2019). Screening Heroin Smokers attending Community Drug Services, for COPD. Chest Journal; 155 (2) pp279-287.

Burhan, H., Young, R. Byrne, T. Peat. R. Furlong J., Renwick, S., Elkin, T., Oelbaum, S. and Walker, P.P. (2019). Screening Heroin Smokers Attending Community Drug Services for COPD. Chest; 155(2) pp279-287.

Burling T. A., Seidner A. L., Robbins-Sisco, D., Krinsky, A. and Hanser S. B. (1992). Batter Up! Relapse Prevention for Homeless Veteran Substance Abusers via Softball Team Participation. Journal of Substance Abuse; 4 pp407-413.

Carbo, P.A. (2008). Reflexive Practice as Ethics and Political Position: Analysis in an Ethnographic Study of Heroin Use. Qualitative Social Work; 7(4) pp466–483.

Carlson, R.G. (2000). Shooting Galleries, Dope Houses, and Injection Doctors: Examining the Social Ecology of HIV Risk Behaviors Among Drug Injectors in Dayton, Ohio. Human Organisation; 59(3) pp325-333.

Carman, R.S. (1979). Motivations for Drug Use and Problematic Outcomes Among Junior High School Students. Addictive Behaviors; 4 pp91-3.

Carnwath, T. and Smith, I. (2003). Heroin Century. Routledge, London.

Casey, E.S. (1997). The Fate of Place: A Philosophical History. University of California Press, Los Angeles.

Castleberry, A. and Nolen, A. (2018). Thematic Analysis of Qualitative Research Data: Is It As Easy As It Sounds? Currents in Pharmacy Teaching and Learning; 10, pp807-815.

Ceccato, V.A. (2016). Rural Crime and Community Safety. Routledge, New York.

Celentano, D.D., Vlahov, D., Cohn, S., Anthony, J.C., Solomon, L. and Nelson, K.E. (1991). Risk Factors for Shooting Gallery Use and Cessation Among Intravenous Drug Users. American Journal of Public Health; 81(10) pp1291-5.

Center for Substance Abuse Treatment (2005). National Summit on Recovery Conference Report. Washington D.C.

Centers for Disease Control and Prevention (2017). CDC Reports Rising Rates of Drug Overdose Deaths in Rural Areas. {Internet} (Available) at: https://www.cdc.gov/media/releases/2017/p1019-rural-overdose-deaths.html (Accessed April 17th, 2019).

Centers for Disease Control and Prevention (2022). Vital Statistics Rapid Release. {Internet} Available at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (Accessed January 23rd, 2022).

Centre for Substance Abuse Treatment (2009). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we Know from the Research? U.S. Department of Health and Human Sciences. {Internet} Available at: http://www.samhsa.gov (Accessed August 1st, 2019).

Cestone, L. (2019). Does Poverty Cause Addiction? Comparing Experiences with Alcoholism and Substance Abuse by Social Class, Race and Ethnicity. SUNY Oneonta Academic Research; 3 pp1-11.

Chamberlain, K. and Hodgetts, D. (2018). Collecting Qualitative Data with Hard-to-Reach Groups. In Flick, U. (ed.). The SAGE Handbook of Qualitative Data Collection. SAGE, London.

Chein, I. (1966). Some Sources of Divisiveness Among Psychologists. American Psychologist; 21(4) 333–342.

Chiseri-Strater, E. and Sunstein, B.S. (1997). Field Working: Reading and Writing Research. Blair Press, New Jersey.

Cicero, T.J., Ellis, M.S. Surrat, H.L. and Kurtz, S.P. (2014). The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 years. JAMA Psychiatry; 71(7) pp821-826.

Clark, M.C. and Sharf, B.F. (2007). The Dark Side of Truth(s) Ethical Dilemmas in Researching the Personal. Qualitative Inquiry Volume; 13(3) pp399-416.

Clinard, M.B. (1952). The Black Market: A Study of White-Collar Crime. Rinehart and Co., New York.

Clinard, M.B. and Meier, R.F. (2011). Sociology of Deviant Behaviour. Wadsworth, California.

Cloke, P., Marsden, T., Mooney, P. (2006). Handbook of Rural Studies. SAGE Publications, London.

Cloke, P., Milbourne, P. and Widdowfield, R. (2000). Homelessness and Rurality: "Out-of-Place" in Purified Space? Environment and Planning D: Society and Space; 18 pp715-735.

Cloud, D.H., Ibragimova, U., Prooda, N., Young, A. M. and Cooper, H. L.F. (2019). Rural Risk Environments for Hepatitis C Among Young Adults in Appalachian Kentucky. International Journal of Drug Policy; 72 pp47-54.

Cloud, W. and Granfield, R. (2008). Conceptualizing Recovery Capital: Expansion of a Theoretical Construct. Substance Use & Misuse; 43: pp1971–1986.

Coffey, A. and Flick, U. (2018). Doing Ethnography. SAGE, London.

Coomber, R. (1999). The Cutting of Heroin in the United States in the 1990s. Journal of Drug Issues; 29(1) pp17-36.

Copp, J.H. (1972). Rural Sociology and Rural Development. Rural Sociology; 37(4) pp515-533.

Corrigan, P.W., Schomerus, G., Shuman, V., Kraus, D., Perlick, D., Harnish, A., Kulesza, M., Kane-Willis, K., Qin, S., and Smelson, D. (2016). Developing a research agenda for understanding the stigma of addictions Part I: Lessons from the Mental Health Stigma Literature. The American Journal on Addictions; 26 pp 59–66.

Corrigan, P.W., Schomerus, G., Shuman, V., Kraus, D., Perlick, D., Harnish, A., Kulesza, M., Kane-Willis, K., Qin, S., and Smelson, D. (2016). Developing a Research Agenda for Reducing the Stigma of Addictions, Part II: Lessons From the Mental Health Stigma Literature. The American Journal on Addictions; XX pp1–8.

Cormack, D. (2000). The Research Process in Nursing. Blackwell Science, Oxford.

Cresswell, J.W. (2009). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. SAGE, California.

Cronk, C.E. and Servela, P.D. (1997). Alcohol, Tobacco and Other Drug Use Among Rural/Small Town and Urban Youth: A Secondary Analysis of the Monitoring the Future Data Set. American Journal of Public Health; 87 pp760-764.

Cross J.E. (2001). What is "Sense of Place"? Archives of the Twelfth Headwaters Conference, November 2-4.

Crossley, N. (2007). Researching Embodiment by Way of "Body Techniques". The Editorial Board of the Sociological Review. pp81-94

Cunningham-Fletcher, A. and Flesche, F.L. (1911). The Omaha Tribe. U.S. Government Printing Office, Washington D.C.

Curry, M.R. (1998). Digital Places: Living with Geographic Information Technologies. Routledge, New York.

Cutler, F. (2007). Context and Attitude Formation: Social Interaction, Default Information, or Local Interests? Political Geography; 26 pp575-600.

Dahl, S.L. (2015). Remaining a User While Cutting Down: The Relationship Between Cannabis Use and Identity. Drugs: Education, Prevention and Policy; 22(3) pp175–184.

Darke, S. (2016). Heroin Overdose. Addiction; 111 pp2060–2063.

Darke, S. and Zador, D. (1996). Fatal Heroin "Overdose": A Review". Addiction; 91(12) pp1765-1772.

Darke, S., Ross, J., Mills, K.L., Williamson, A., Havard, A. and Teesson, M. (2007). Patterns of Sustained Heroin Abstinence Amongst Long-Term, Dependent Heroin Users: 36 Months Findings from the Australian Treatment Outcome Study (ATOS). Addictive Behaviours; 32 pp1897–1906.

Davenport-Hines, R. (2001). The Pursuit of Oblivion: A Social History of Drugs. Phoenix Press, London.

Davies, J.B. (1993). The Myth of Addiction. Harwood Academic Publishers, Switzerland.

Davies, J.B. (1996). Reasons and Causes: Understanding Substance Users' Explanations for Their Behaviour. Human Psychopharmacology; 11 pp39-48.

Davis, K. (1997). Embodied Practices: Feminist Perspectives on the Body. SAGE, London.

Dawson, K. (2009). Introduction to Research Methods: 4th edition: A Practical Guide for Anyone Undertaking a Research Project. How to Books, Oxford.

de Certeau, M. (1984). The Practice of Everyday Life. University of California Press, Berkeley.

Decorte, T. (2000). Drug Users' Perceptions of "Controlled" and "Uncontrolled" Use. International Journal of Drug Policy; 12 pp297–320.

Delargy, I., Cowly, D. and Van Hout, M.C. (2019). Twenty Years of the Methadone Treatment Protocol in Ireland: Reflections on the Role of General Practice. Harm Reduction Journal; 16:5 pp1-10.

DeKeseredy, W., Donnermeyer, J., Schwartz, M., Tunnell, K., and Hall, M. (2007). Thinking Critically About Rural Gender Relations: Toward a Rural Masculinity

Crisis/male Peer Support Model of Separation/divorce Sexual Assault. Critical Criminology; 15 pp 295–311.

Dennis, F. (2016). Drugs: Bodies Becoming “Normal”. M/C Journal; 19(1).

Denscombe, M. (2009). Ground Rules for Social Research: Guidelines for Good Practice. Open University Press, Berkshire, U.K.

Denscombe, M. (2010). The Good Research Guide: For Small-Scale Social Research Projects. McGraw-Hill Education, New York.

Denzin, N.K. and Lincoln, Y.S. (2008). Collecting and Interpreting Qualitative Materials. SAGE Publications, London.

Denzin, N.K. and Lincoln, Y.S. (2017). Strategies of Qualitative Enquiry. SAGE Publications, London.

Desai, A.R. (2005). Rural Sociology in India. The Indian Society of Agriculture Economics, Mumbai.

Dietze, P., Jolley, D., Fry, C. and Bammer, G. (2005). Transient Changes in Behaviour Lead to Heroin Overdose: Results from a Case-Crossover Study of Non-Fatal Overdose. Addiction; 100 pp636– 642.

Dolan, S.B, Johnson, M.W. Dunn, K.E. and Huhn, A.S. (2021). The Discounting of Death: Probability Discounting of Heroin Use by Fatal Overdose Likelihood and Drug Purity. American Psychological Association; 29(3) pp219–228.

Dole, V. and Nyswander, M. (1967). Heroin Addiction: A Metabolic Disease. Archives of Internal Medicine; 120, pp19-24.

Donnermeyer, J., Scott, J. and Barclay, E. (2013). How Rural Criminology Informs Critical Thinking in Criminology. International Journal for Crime, Justice and Social Democracy; 2(3) pp69-91.

Donnermeyer, J. F. (2016). The Routledge International Handbook of Rural Criminology. Routledge, London.

Donnermeyer, J. F. (1997). The Economic and Social Costs of Drug Abuse Among the Rural Population. In Robertson, E. B., Sloboda, Z., Boyd, G.M., Beatty, L. and Kozel, N.J. (Eds), Rural Substance Use: State of Knowledge and Issues. MD National Institute of Health, Rockville.

Dorn, N. and South, N. (1987). A Land Fit for Heroin? Drug Policies, Prevention and Practice. Macmillan Education, Hampshire.

Dougherty, S.D. and Atkinson, J. (2006). Competing Ethical Communities and a Researchers’ Dilemma: The Case of a sexual Harasser. Qualitative Inquiry; 12(2) pp292-315.

Douglas, M. (1973). Rules and Meanings. The Anthropology of Everyday Knowledge: Selected Readings. Viking Books, New York.

Douglas, M. (ed.). (1987). Constructive Drinking: Perspectives on Drink from Anthropology. Cambridge University Press, Cambridge.

Doukas, N. and Cullen, J. (2009). Recovered, in Recovery or Recovering from Substance Abuse? A Question of Identity. Journal of Psychoactive Drugs; 41(4) pp391-394.

Draus, P.J., Roddy, J. and Asabigi, K. (2015). Streets, Strolls and Spots: Sex Work, Drug Use and Social Space in Detroit. International Journal of Drug Policy; 26 (5) pp453-460.

Draus, P.J., Roddy, J. and Greenwald, M. (2010). "I Always Kept a Job": Income Generation, Heroin Use and Economic Uncertainty in 21st Century Detroit. Journal of Drug Issues; 40(4) pp841–869.

Drumm, R. D., McBride, D., Metch, L., Neufeld, M. and Sawatsky, A. (2005). I'm a Health Nut!" Street Drug Users' Accounts of Self-care Strategies. Journal of Drug Issues; Summer pp607-630.

Ducci, F. and Goldman, D. (2012). The Genetic Basis of Addictive Disorders. Psychiatric Clinics of North America; 35(2) pp495-519.

Duke, K. (2013). From Crime to Recovery: The Reframing of British Drugs Policy? Journal of Drug Issues; 43(1) pp39–55.

Dumfries and Galloway NHS (2017). Dumfries and Galloway NHS Research Ethics Committee, Dumfries.

Dunn, K.E., Huhn, A.S. and Strain, E.C. (2019). Differential Adoption of Opioid Agonist Treatments in Detoxification and Outpatient Settings. Journal of Substance Abuse Treatment; 107 pp24-28.

Durkheim, E. (1933). The Division of Labour in Society. Macmillan, New York.

Duterte, M., O'Neil, S., McKearin, G., Sales, P., Murphy, T. and Murphy, S. (2011). Walking the Tightrope: Balancing Health and Drug Use. Journal of Psychoactive Drugs; 33(2) pp173-183.

Earp, B.D., Skorburg, J.A., Everett, J. A. C. and Savulescu, J. (2019). Addiction, Identity, Morality. AJOB Empirical Bioethics; 10(2) pp136-153.

Edwards, G. and Gross, M.M. (1976). Alcohol Dependence: Provisional Description of a Clinical Syndrome; British Medical Journal, 1 pp1058-61.

Edwards, R. W. (1997). Drug and Alcohol Use Among Youth in Rural Areas; Cited in National Institute on Drug Research Monograph Series. Rural Substance Abuse: State of Knowledge and Issues, NIDA Research Monograph 168.

Einstein, S. (1983). Drug Misuse Intervention: The Existence of the Fallacy of Misplaced Reification and Chemical Deification. The International Journal of the Addictions; 18(1) ppiii-iv.

Eisenstein, E., Aquino, M.T., Caldeira, Z., Freire, Z. and Baptista, M. (2005). Youth and Drugs in Brazil: Social Imbalance and Health Risks, pp121-133. In Obot, I.S. and Saxena, S. (eds.). Substance Use Among Young People in Urban Environments. World Health Organization, Geneva.

El-Guebaly, N. (2012). The Meanings of Recovery from Addiction: Evolution and Promises. Journal of Addiction Medicine; 6(1) pp 1–9.

Elinson, Z. and Campo-Flores, A. (2013). Heroin Makes a Comeback. Wall Street Journal (August 8).

Ercikan, K. and Roth, W.M. (2009). A Review of "Generalizing from Educational Research: Beyond Qualitative and Quantitative Polarization". Routledge, New York.
Erikson, K. T. (1964). "Notes on the Sociology of Deviance". In Becker, H. (ed.). The Other Side: Perspectives on Deviance. Free Press, New York.

Ettorre, E. (1992). Women and Substance Use. Macmillan, Basingstoke.

European Monitoring Centre for Drugs and Drug Addiction (2008). The State of the Drugs problem in Europe: Annual Report. Cais do Sodré, Lisbon.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019). National Report: United Kingdom, New Developments, Trends and In-depth Information on Selected Issues. London.

Evans, C.B.R, Cotter, K.L. Rose, R.A. and Smokowski, P.R. (2019). Substance Use in Rural Adolescents: The Impact of Social Capital, Anti-social Capital, and Social Capital Deprivation. Journal of Addictive Disease; 0 (0) pp1-14.

Farrugia, D. (2016). Youth Homelessness in Late Modernity: Reflexive Identities and Moral Worth. Springer, Singapore.

Fenichel, O. (1945). The Psychoanalytic Theory of Neurosis. W. W. Norton & Co., New York.

Fereday, J. and Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International Journal of Qualitative Methods; 5(1) pp80-92.

Fetterman, D.M. (2020). Ethnography: Step-by-Step. SAGE, London.

Fine, G.A. (1995). A Second Chicago School; University of Chicago Press, Chicago.

Finestone, H. (1957). Cats, Kicks and Color. Social Problems; 5 (1) pp3-13.

Fingarette, H. (1988). Heavy Drinking. University of California Press, California.

Finlay, L. (2000). Multiple Voices, Multiple Paths: Choosing Between Qualitative Traditions. British Journal of Occupational Therapy; 63(12) pp580-582.

Fisher, B. and Straus, A. (1978). The Chicago Tradition and Social Change: Thomas, Park and Their Successors. Symbolic Interaction; 1(2) pp5-23.

Fletcher, H.B. (2008). Gender and the American Temperance Movement of the Nineteenth Century. Routledge, New York.

Flick, U. (2014). The SAGE Handbook of Qualitative Data Analysis. SAGE, London.

Flore, J., Kokanovića, R. Callard, F., Broom, A. and Duffeet, C. (2019). Unravelling Subjectivity, Embodied Experience and (Taking) Psychotropic Medication. Social Science & Medicine; 230 pp66–73.

Foley. D.E. (2002). Critical Ethnography: The Reflexive Turn. International Journal of Qualitative Studies in Education; 15(4) pp469-490.

Forsyth, A.J.M. and Barnard, M. (1999). Contrasting Levels of Adolescent Drug Use Between Adjacent Urban and Rural Communities in Scotland. Addiction; 94(11) pp1707-1718.

Foucault, M. (1967). Madness and Civilisation. Vintage, New York.

Foucault, M. (1980). POWER/KNOWLEDGE: Selected Interviews and Other Writings 1972-1977. Gordon, C (ed.). Pantheon Books, New York.

Foucault, M. (1984). Of Other Spaces: Utopias and Heterotopias 1967. Architecture /Mouvement/ Continuité; October pp 1-9.

Foucault, M. (1994). The Order of Things: An Archaeology of the Human Sciences. Vintage, New York.

Foucault, M. (1994). Discipline and Punish: The Birth of the Prison. Penguin Philosophy, London.

Fourcade, M. (2010). The Problem of Embodiment in the Sociology of Knowledge: Afterword to the Special Issue on Knowledge in Practice. Qualitative Sociology; 33 pp569–574.

Foxcroft, L. (2008). The Making of Addiction: The “Use and Abuse” of Opium in Nineteenth Century Britain: The History of Medicine in Context. Ashgate, Aldershot.

Fram, S.M. (2013) The Constant Comparative Analysis Method Outside of Grounded Theory. The Qualitative Report; 18 (1) pp25.

Fraser, S. and Moore, D. (2008). Dazzled by Unity? Order and Chaos in Public Discourse on Illicit Drug Use. Social Science and Medicine; 66 pp740-752.

Fredrickson, B.L. and Joiner, T. (2002). Positive Emotions Trigger Upward Spirals Toward Emotional Well-Being. American Psychological Society; 13(2) pp172-175.

Freedman, A.M. and Wilson, E.A. (1964). Childhood and Adolescent Addictive Disorders. Paediatrics; 34 pp283-92.

Fusch, P.I. and Ness, L.R. (2015). Are We There Yet? Data Saturation in Qualitative Research. The Qualitative Report; 20(9) pp1408-1416.

Gabe, J., Bury, M. and Elston, M.A. (2004). Key Concepts in Medical Sociology, SAGE, London.

Galanter, M. (2007). Spirituality and Recovery in 12-Step Programs: An Empirical Model. Journal of Substance Abuse Treatment; 33 pp265–272.

Gans, H.J. (1999). Participant Observation in the Era of "Ethnography". Journal of Contemporary Ethnography; 28(5) pp540-548.

Gavriel-Fried, B., Moretta, T. and Potenza, M.N. (2020). Recovery Capital and Symptom Improvement in Gambling Disorder: Correlations with Spirituality and Stressful Life Events in Younger but Not Older Adults. Journal of Gambling Studies; 36 pp1379–1390.

Geertz, C. (1972). The Interpretation of Cultures. Hutchinson, London.

Geertz, C. (2000). Local Knowledge: Further Essays In Interpretive Anthropology. Basic Books, U.S.A.

Gerard, D.L. and Kornetsky, C. (1955). Adolescent Opiate Addiction: A Study of Control and Addict Subjects. Psychiatric Quarterly; 29(3) pp457-86.

Gfroerer, J.C., Larson, S. and Colliver, J.D. (2007). Drug Use Patterns and Trends in Rural Communities. Journal of Rural Health; 23 pp10-15.

Gibson, B., Acquah, S. and Robinson, P.G. (2004). Entangled Identities and Psychotropic Substance Use. Sociology of Health and Illness; 26 pp597–616.

Giddens, A. and Sutton, P.W. (2017). Essential Concepts in Sociology. Polity Press, Cambridge.

Gieryn, T.F. (2000). A Space for Place in Sociology. Annual Review of Sociology; 26 pp463-496.

Gilbert, J. G. and Lombardi, D. N. (1967). Personality Characteristics of Young Male Narcotic Addicts. Journal of Consulting Psychology; 31(5) pp536–538.

Gilchrist, G., Swan, D., Shaw, A., Keding, A., Towers, S., Craine, N., Munro, A., Hughes, E., Parrott, S. Mdege, N., Strang, J., Taylor, A. and Watson, J. (2017). Preventing Blood-borne Virus Infection in People Who Inject Drugs in the UK:

Systematic Review, Stakeholder Interviews, Psychosocial Intervention Development and Feasibility Randomised Controlled Trial. Health Technology Assessment 21(72).

Gili, A., Lancia, M., Mercurio, I., Bacci, M., Nicoletti, A., Pelliccia, C. and Gambelungh, C. (2022). Patterns of Prescription Medicine, Illicit Drugs, and Alcohol Misuse among High-Risk Population: A Factor Analysis to Delineate Profiles of Poly-drug Users. Healthcare; 10(710) pp1-9.

Glaser, B. (1992). Basics of Grounded Theory Analysis. Sociology Press, California.

Glaser, B. (1965). The Constant Comparative Method of Qualitative Analysis. Social Problems; 12, (4), pp. 436-445.

Glasser, I. (2012). Anthropology of Addictions and Recovery. Waveland Press Inc, Illinois.

Glatt, M. M. (1968). "The Alcoholic Problem in Great Britain - Recent Developments". In Odium, D. and Walk, A. (eds.). The Expanding Field of Mental Health in England and Wales, 50 years of progress, 1918-1968. No Publisher.

Goffman, E. (1957). The Presentation of Self in Everyday Life. Penguin, Harmondsworth.

Goffman, E. (1963). Stigma Notes on Management: Notes on the Management of a Spoiled Identity. Simon and Schuster, New York.

Goodman, J. (1995). Consuming Habits: Drugs in History and Anthropology. Routledge, London.

Gottdiener, M. and Hutchison, R. (2014). The New Urban Sociology. Westview Press, Colorado.

Goulding, C. (2002). Grounded Theory A Practical Guide for Management, Business and Market Researchers. Sage, London.

Gowan, T., Whetstone, S. and Andic, T. (2012). Addiction, Agency, and the Politics of Self-Control. Social Science and Medicine; 74 pp1251–1260.

Granfield, R. and Cloud, W. (1999). Coming Clean: Overcoming Addiction Without Treatment. New York University Press, New York.

Granfield, R. and Cloud, W. (2001). Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug-associated Problems. Substance Use and Misuse; 36(11) pp1543–1570.

Groenewald, T. (2004). A Phenomenological Research Design Illustrated. International Journal of Qualitative Methods; 3(1). Article 4, pp1-26.

Groshkova, T., Best, D. and White, W. (2013). The Assessment of Recovery Capital: Properties and Psychometrics of a Measure of Addiction Recovery Strengths. Drug and Alcohol Review; 32 pp187–194.

Gross, M. (2010). Alcoholics Anonymous: Still Sober After 75 Years. American Journal of Public Health; 100(12) pp2361-2363.

Grund, J. C. (1993). Drug Use as a Social Ritual: Functionality, Symbolism and Determinants of Self-Regulation. Drug Use as a Social Ritual, Rotterdam.

Gryczynski, J., Grady, K. and Jaffe, J. (2009). Treatment Entry Among Individuals on a Waiting List for Methadone Maintenance. The American Journal of Drug and Alcohol Abuse; 35 pp290–294.

Gudeman, S. (2001). The Anthropology of Economy Community, Market, and Culture. Blackwell Publishers, Oxford.

Gundy, K. V. (2006). Substance Abuse in Rural and Small-town America. Carsey Institute Report on Rural America; 1(2) pp1-28.

H.M. Government (2010). Drug Strategy: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life. H.M. Government, London.

Hall, S. (1997). Representation: Cultural Representations and Signifying Practices. SAGE Publications, London.

Hammersley, M. and Atkinson, P.A. (2007). Handbook of Ethnography. Routledge, London.

Hammersley, R. and Reid, M. (2002). Why the Pervasive Addiction Myth is Still Believed. Addiction Research & Theory; 10(1) pp7–30.

Hänninen, V. and Koski-Jännes, A. (1999). Narratives of Recovery from Addictive Behaviours. Addiction; 94 (12) pp1837-1848.

Harkness, A. (2020). Rural Crime Prevention: Theory, Tactics and Techniques. Routledge, Oxon.

Harling, M.R. (2007). The Place and Meaning of “Controlled”, Illicit Substance Use in the Private Lives of a Group of Individuals. Journal of Substance Use; 12(1) pp1-12.

Harper, P. (2008). Ethnomethodological Ethnography and its Application in Nursing. Journal of Research in Nursing; 13(4) pp311-323.

Harper, S. (1987). A Humanistic Approach to the Study of Rural Populations. Journal of Rural Studies; 3(4) pp309-319.

Harper, D. and Thompson, A. R. (2011). Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners. Wiley and Son,

Harrison, K. Vlahov, D. Jones, K., Charron, K. and Clements, M.L. (1995). Medical Eligibility, Comprehension of the Consent process, and Retention of Injection Drug Users recruited for an HIV Vaccine Trail. Journal of Acquired Immune Deficiency's Syndromes and Human Retrovirology; 10, pp386-390.

Harrison, S. and Dourish, P. (1996). Re-Place-ing Space: The Roles of Place and Space in Collaborative Systems, CSCW Paper.

Harvey, D. (2004). Space as a Key Word. Paper for Marx and Philosophy Conference, 29 May; Institute of Education, London.

Harvey, L. (1987). The Nature of Schools in the Sociology of Knowledge: The Case of the Chicago School. The Sociological Review; 35 (2) pp 245–278.

Harvey, L. (2012). Chicago School. {Internet} (Available) at: http://www.qualityreserachinternational.com/socialresearch/chicagoschool.htm (Accessed 12th March 2019).

Hay, G., Gannon, M., McKeganey, N.P., Hutchinson, S. and Goldberg, D. (2005). Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland. Scottish Executive, Edinburgh.

Heil, S.H., Sigmon, S.C., Jones, H.E. and Wagner, M. (2008). Comparison of Characteristics of Opioid-Using Pregnant Women in Rural and Urban Settings. The American Journal of Drug and Alcohol Abuse; 34, pp463-471.

Heller, T., Gott, M. and Jeffery, C. (1987). Drug Use and Misuse. John Wiley and Son, Chichester.

Hennessy, E.A. (2017). Recovery Capital: A Systematic Review of the Literature. Addiction Research & Theory; pp1-12.

Herman, E. Bentley, M.E. (1992). Manuals For Ethnographic Data Collection: Experience and Issues. Social Science and Medicine; 35(11) pp1369-78.

Herriman, N. (2020). Embodiment: Concepts in Anthropology. (Personal Correspondence 9th July 2020) linked to {Internet} (Available) at: https://www.youtube.com/watch?v=JF7ksSmd4Wg (Accessed 9th July 2020).

Herring, J., Regan, C., Weinberg, D. and Withington, P. (2013). Intoxication and Society: Problematic Pleasures of Drugs and Alcohol. Palgrave Macmillan, London.

Hill, J. and Leeming, D. (2014). Reconstructing "The Alcoholic": Recovering from Alcohol Addiction and the Stigma this Entails. International Journal of Mental Health and Addiction; pp1557-1874.

Hockey, J. and Forsey, M. (2012). Ethnography is not Participant Observation: Reflections on the interview as participatory qualitative research. In Skinner, J. (ed.), The interview: An ethnographic approach; pp. 69–87.

Hoffer, L.D. (2016). The Space Between Community and Self-Interest: Conflict and the Experience of Exchange in Heroin Markets. The Economics of Ecology, Exchange, and Adaptation: Anthropological Explorations Research in Economic Anthropology; 36 pp167-196.

Holt, M. and Treloar, C. (2007). Managing Mental Health Problems in Everyday Life: Drug Treatment Clients' Self-care Strategies. International Journal of Mental Health Addiction; 6 pp 421-43.

Hser, Y., Longshore, D. and Anglin M.D. (2007). The Life Course Perspective on Drug Use—A Conceptual Framework for Understanding Drug Use Trajectories. Evaluation Review; 31 pp515–47.

Hughes, K. (2007). Migrating Identities: The Relational Constitution of Drug Use and Addiction. Sociology of Health & Illness; 29(5) pp673–691.

Hughes, R. (1998). Considering the Vignette Technique and its Application to a Study of Drug Injecting and HIV Risk and Safer behaviour. Sociology of Health and Illness; 20(3) pp381- 400.

Humphreys, K. (2015). Addiction Treatment Professionals are not the Gatekeepers of Recovery. Substance Use and Misuse; 50(8-9) pp1024–1027.

Hurley, W.L., Denegar, C.R. and Hertel, J. (2011). Research Methods: A Framework for Evidence-based Clinical Practice. Wolters Kluwer/Lippincott Williams & Wilkins Health, Philadelphia.

Hycner, R.H. (1985). Some Guidelines for the Phenomenological Analysis of Interview Data. Human Studies; 8 pp279-303.

Iacono, J., Brown, A. and Holtham, C. (2009) Research Methods – A Case Example of Participant Observation. The Electronic Journal of Business Research Methods; 7 (1) pp.39-46.

Inanlou, M., Bahmani1, B., Farhoudian, A. and Rafiee, F. (2020). Addiction Recovery: A Systematized Review. Iranian Journal of Psychiatry; 15(2) pp172-181.

Inciardi, J.A. (1979). Methadone Diversion: Experience and Issues. National Institute on Drug Abuse. Washington.

Information Services Division (ISD) (2015). Estimating the National and Local Prevalence of Problem Drug Use in Scotland. National Health Service, Scotland.

Information Services Division (ISD) (2016). Prevalence of Problem Drug Use in Scotland. National Health Service, Scotland.

International Statistical Classification of Diseases and Related Health Problems tenth revision (I.C.D. 10- {F1x2}) (2015). World Health Organization, Geneva.

Jaffe, J., Petersen, R, and Hodgson, R. (1980). Addictions: Issues and Answers. Harper and Row, London.

Janssen, E. (2017). Estimating the Number of Heroin Users in Metropolitan France Using Treatment Centers Data: An Exploratory Analysis. Substance Use & Misuse; 52(5) pp683-687.

Jansson, A. (2013). The Hegemony of the Urban/Rural Divide: Cultural Transformations and Mediatized Moral Geographies in Sweden. Space and Culture; 16(1) pp88–103.

Jelsma, M. (2003). Drugs in the UN System: The Unwritten History of the 1998 United Nations General Assembly Special Session on Drugs. International Journal of Drug Policy; 14 pp181-195.

Jobes, P.C., Barclay, E. and Weinand, H. (2004). A Structural Analysis of Social Disorganisation and Crime in Rural Communities in Australia. Journal of Criminology; 37(1) pp114-140.

Johnson, M.D., Heriza, T.J. and St. Dennis, C. (1999). How to Spot Illicit Drug Abuse in your Patients. Postgraduate Medicine; 106(4) pp199-218.

Johnson, T.G. and Scott, J.K. (1997). The Changing Nature of Rural Communities. Increasing Understanding of Public Problems and Policies; pp177-188.

Jonas, A.B., Young, A.M., Oser, C.G. Leukefeld, C.G. and Havens, J.R. (2012). OxyContin as Currency: OxyContin Use and Increased Social Capital Among Rural Appalachian Drug Users. Social Science & Medicine; 74 pp1602-1609.

Jones C.M., Logan, J., Gladden, R.M. and Bohm, M.K. (2015). Vital Signs: Demographic and Substance Use Trends Among Heroin Users—United States, 2002–2013. Morbidity and Mortality Weekly Report; 64(26) pp719–725.

Jones, J. and Smith, J. (2017). Ethnography: Challenges and Opportunities. Evidenced Based Nursing; 20(4) pp 98-100.

Jones, J.D., Mogali, S. and Comer, S.D. (2012). Polydrug Abuse: A Review of Opioid and Benzodiazepine Combination Use. Drug and Alcohol Dependence; 125 pp8-18.

Jorgensen B. S. and Stedman R. C. (2001). Sense of Place as an Attitude: Lakeshore Owners Attitudes Towards Their Properties. Journal of Environmental Psychology; 21 pp233-248.

Judd, F., Cooper, A., Fraser, C. and Davis, J. (2006). Rural Suicide-People or Place Effects? Australian and New Zealand Journal of Psychiatry; 40 pp208-216.

Kalekin-Fishman, D. (2013). Sociology of Everyday Life. Current Sociology; 61(5-6) pp714-732.

Kaplan, C. and Verbraek, H. (2001). Where Have All the Fieldnotes Gone? The Changing Nature and Politics of Drugs Ethnography in the Netherlands. Addiction Research & Theory; 9(4) pp299-323.

Karpman, B. (1948). The Myth of the Psychopathic Personality. The American Journal of Psychiatry; 104 pp523–534.

Kawulich, B.B. (2005). Participant Observation as a Data Collection Method. Qualitative Social Research; 6 (2) pp1-28.

Kaylen, M.T. and Pridemore, W.A. (2013). The Association Between Social Disorganization and Rural Violence Is Sensitive to the Measurement of the Dependent Variable. Criminal Justice Review; 38(2) pp169-189.

Keane, H. (2003). Critiques of Harm Reduction, Morality and the Promise of Human Rights. International Journal of Drug Policy; 14 pp227–232.

Keene, J. (1997). Drug Misuse, Prevention, Harm Minimisation and Treatment, Chapman and Hall, London.

Keene, J. and Raynor, P. (1993). Addiction as Soul Sickness: The Influence of Client and Therapist Beliefs. Addiction Research; 1(1) pp77-87.

Keene, J., Stimson, G.V., Jones, S. and Parry-Langdon, N. (1993). Evaluation of Syringe Exchange for HIV Prevention Among Injecting Drug Users in Rural and Urban Areas of Wales. Addiction; 88 pp1063-1070.

Keightley, E. and Pickering, M. (2013). Research Methods for Memory Studies. Cambridge University Press, Cambridge.

Kelly, J.F. and Hoeppner, B. (2014). A Biaxial Formulation of Recovery Construct. Addiction Research and Theory; 23(1) pp5-9.

Kelly, J. F. and White, W. L. (2011). Addiction Recovery Management: Theory, Research and Practice. Humana Press/Springer Nature, London.

Kemp, R. (2013). Rock-Bottom As an Event of Truth. Journal of The Society for Existential Analysis; 24(1) pp106-116.

Kesteloop, C. Loopmans, M. and De Deckeer, P. (2009). Space in Sociology: An Exploration of a Difficult Conception. In De Boyser, K., DeWilde, C. Dierckx, D. and Friedrichs, J (eds.). Between the Social and the Spatial, Exploring the Multiple Dimensions of Poverty and Social Exclusion. Ashgate, Farnham.

Keuhn, B.M. (2014). Pain Medication Abuse a Common Path to Heroin Resurgence. JAMA; 310(14) pp1433-4.

Khorasheh, T., Naraine, R. and Watson, T.M. (2019). A Scoping Review of Harm Reduction Training for Police Officers: Police Harm Reduction Training. Drug and Alcohol Review; 38(2) pp131-150.

Kilmer, B., Caulkins, J.P., Pacula, R.L. and Reuter, P.H. (2011). The U.S. Drug Policy Landscape: Insights and Opportunities for Improving the View. RAND Drug Policy Research Center, Santa Monica.

Klaue, K. (1999). Drugs, addiction, deviance and disease as social constructs. United Nations Office on Drug and Crime Bulletin on Narcotics; 1(1-2).

Klee, G.D. (1970). Drugs and American Youth. In Hermann, R.E. and Fox, A.M. (eds.). Drug Awareness. Avon, New York.

Knox, P.L. (2005). Creating Ordinary Places: Slow Cities in a Fast World. Journal of Urban Design; 10. (1) pp1–11.

Koebler, J. (2014). Heroin Ravages Rural America. {Internet} Available at: https://www.usnews.com/news/articles/2014/02/07/philip-seymour-hoffmans-death-highlights-growing-heroin-epidemic (Accessed 10th February 2016).

Kopak, A.M, Lawson, S.W. and Hoffman, N.G. (2017). Criminal Justice Contact and Relapse Among Patients Seeking Treatment for Opioid Use Disorder. Journal of Drug Issues; 48(1) pp134-147.

Korntesky, C. (1954). Effects of Anxiety and Morphine on the Anticipation and Perception of Painful Radiant Thermal Stimuli. Journal of Comparative and Physiological Psychology; 47(2) pp130–132.

Kurtz, E. and White, W. (2002). Alcoholics Anonymous. In Blocker, J., Fahey, D. and Tyrell, I. (eds.). Alcohol and Temperance in Modern History: An International Encyclopaedia. Santa Barbara, California.

Kutsche, P. (1998). Field Ethnography: A Manual for Doing Cultural Anthropology. Prentice Hall, New Jersey.

Lahaie, E., Janssen, E. and Cadet-Tairou, A. (2015). Determinants of Heroin Retail Prices in Metropolitan France: Discounts, Purity and Local Markets. Drug and Alcohol Review; 35(5) pp597-604.

Lancaster, K., Ritter, A., Valentine, K. and Rhodes, T. (2019). "A More Accurate Understanding of Drug Use": A Critical Analysis of Wastewater Analysis Technology for Drug Policy. International Journal of Drug Policy; 63 pp47–55.

Lancaster, K., Duke, K. and Ritter, A. (2015). Producing the "Problem of Drugs": A Cross National-Comparison of "Recovery" Discourse in Two Australian and British Reports. International Journal of Drug Policy; 26(7) pp617-625.

Lander, L.R., Marshalek, P., Yitayew, M., Ford, D., Sullivan, C.R. and Gurka, K.K. (2013). Rural Healthcare Disparities: Challenges and Solutions for the Pregnant Opioid-Dependent Population. West Virginia Medical Journal; 109(4) pp22-29.

Larkin, M. and Griffiths, M.D. (2002). Experiences of Addiction and Recovery: The Case for Subjective Accounts. Addiction Research and Theory; 10 pp281–311.

Larsson, S. (2009). A Pluralist View of Generalization in Qualitative Research. International Journal of Research & Method in Education; 32(1) pp25-38.

Laskowitz, D. and Einstein S. (1965). Goal Behavior of Adolescent Addicts and Delinquent Non-Addicted Peers. Psychological Reports; 17(1) pp102.

Latkin, C., Mandell, W., Vlahov, D., Knowlton, A., Oziemkowska, M. and Celentano, D. (1995). Personal Network Characteristics as Antecedents to Needle-Sharing and Shooting Gallery Attendance. Social Networks; 17 pp219-228.

Laudet, A. and White, W. (2008). Recovery Capital as Prospective Predictor of Sustained Recovery, Life Satisfaction, and Stress Among Former Poly-Substance Users, Substance Use & Misuse; 43 pp27–54.

Laudet, A. and White, W. (2010). What are your Priorities Right Now? Identifying Service Needs Across Recovery Stages to Inform Service Development. Journal Substance Abuse and Treatment; 38(1) pp51–9.

Laudet, A. B., Becker, J.B and White, W.L. (2009). Don't Wanna Go Through That Madness No More: Quality of Life Satisfaction as a Predictor of Sustained Remission from Illicit Drug Misuse. Substance Use and Misuse; 44 (2) pp227-252.

Laudet, A.B. (2007). What Does Recovery Mean to You? Lessons from the Recovery Experience for Research and Practice. Journal of Substance Abuse and Treatment; 33(3) pp243–256.

Lean, R.E., Pritchard, V.E. and Woodward, L.J. (2013). Child Protection and Out-Of-Home Placement Experiences of Preschool Children Born to Mothers Enrolled in Methadone Maintenance Treatment During Pregnancy. Children and Youth Services Review; 35(11) 1878–1885.

LeCompte, M.D. and Goetz, J.P. (1982). Problems of Reliability and Validity in Ethnographic Research. Review of Educational Research; 52(1) pp31-60.

Leder, D. (1990). The Absent Body. The University of Chicago Press, Chicago.

Leeies, M., Pagura, J., Sareen, J. and Bolton, J.M. (2010). The Use of Alcohol and Drugs to Self-Medicate Symptoms of Post-Traumatic Stress Disorder. Depression and Anxiety; 27(8) pp731-6.

Lefebvre, H. (1991). Critique of Everyday Life Volume I. Verso, London.

Lefebvre, H. (2003). Perspectives on Rural Sociology. In Elden, S. Lebas, E. and Kofman, E. (Eds). Key Writings (pp 111–120). Continuum, London.

Lefebvre, H. (2009). State, Space, World: Selected Essays. University of Minnesota Press, Minneapolis.

Lenardson, J.D., Gale, J.A. and Ziller, E.C. (2016). Rural Opioid Abuse: Prevalence and User Characteristics. Marine Rural Health Research Center; February pp1-10.

Leukefeld, C., Walker, R., Havens, J. Leedham, C.A. and Tolbert, V. (2007). What Does the Community Say: Key Informant Perceptions of Rural Prescription Drug Use. Journal of Drug Issues; Summer, pp503-524.

Levine, H.G. (1978). The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. Journal of Studies on Alcohol; 15 pp493-506.

Lewis, M. (2016). The Biology of Desire: Why Addiction Is Not a Disease. Public Affairs, New York.

Lincoln, Y.S. and Guba, E.G. (1985). Naturalistic Inquiry. SAGE, New York.

Lindesmith, A.R. (1947). Opiate Addiction. Principia Press, Indiana.

Lindesmith, A.R. (1968). Addictions and Opiates. Aldine, Chicago.

Lipsky, M. (1969). Toward A Theory of Street-Level Bureaucracy. Annual Meeting of the American Political Science Association, New York.

Lipton, M. (1977). Why Poor People Stay Poor: Urban Bias in World Development. Temple Smith, London.

Liu, Y., Williamson, V., Setlow, B. Cottler, L.B. and Knackstedt, L.A. (2018). The Importance of Considering Polysubstance Use: Lessons from Cocaine Research. Drug and Alcohol Dependence; 192 pp16-28.

Liukkonen, A. and Åstedt-Kurki, P. (1994). Participant Observation as Data Collection Method in Nursing Research. Hoitotiede; 6(2/-94) pp51-57.

Lofland, J. and Lofland, L.H (1984). Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. University of California, California.

London, M. (2005). History of Addiction: A UK Perspective. The American Journal on Addictions; 14 pp97–105.

Low. S.M. and Lawrence-Zuniga, D. (2004). The Anthropology of Space and Place. Blackwell Publishing, Oxford.

Lukoff, I. F. (1973). Some Aspects of the Epidemiology of Heroin Use on a Ghetto Community. Unpublished MS, University of Columbia, New York.

Luthar, S.S., Barkin, S.H. and Crossman, E.J. (2013). “I Can, Therefore I Must”: Fragility in the Upper-Middle Classes. Development and Psychopathology; 25(402) pp1529–1549.

Lutters, W.G and Ackerman M.S. (1996). An Introduction to the Chicago School of Sociology. Interval Research Proprietary; pp1-23.

Lyons, T. and Lurigio, A. J. (2010). The Role of Recovery Capital in the Community Re-entry of Prisoners with Substance Use Disorders. Journal of Offender Rehabilitation; 49 pp445–455.

MacGregor, S. (2012). Do We Need a European Drugs Strategy? Drugs: Education, Prevention and Policy; 19(6) pp429-435.

MacGregor, S. and Thom, B. (eds.). (2012). Drug and Alcohol Studies. SAGE, London.

Mack, K.A., Jones, C.M. and Ballesteros, M.F. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report; 66(19) pp1–12.

Maggs-Rapport, F. (2001). "Best Research Practice": In Pursuit of Methodological Rigour. Methodological Issues in Nursing Research; 35(3) pp373-383.

Maher, L., Dixon, D., Hall, W. and Lynskey, M. (2002). Property Crime and Income Generation by Heroin Users. The Australian and New Zealand Journal of Criminology; 35(2) pp187-202.

Malinowski, B. (1913). A Scientific Theory of Culture and Other Essays. Oxford University Press, London.

Manning, P. (2007). Drugs and Popular Culture: Drugs, Media and Identity in Contemporary Society. Taylor and Francis, London.

Maris, M. (1971). Deviance as Therapy: The Paradox of the Self-Destructive Female. Journal of Health and Social Behavior; 12(2) pp113-124.

Mars, S. (2003). Heroin Addiction Care and Control: The British System 1916 to 1984. Journal of the Royal Society of Medicine; 96(2) pp99-100.

Mars, S.G., Bourgois, P. and Karandinos, G. (2013). "Every Never I Said Came True": Transitions from Opioid Pills to Heroin Injecting. International Journal of Drug Policy; 25 pp257-266.

Marston, S. A., Jones, J.P III, and Woodward K. (2005). Human Geography without Scale. Transactions of the Institute of British Geographers; 30 pp416-32.

Martin, A. and Stenner, P. (2004). Talking About Drug Use: What Are We (And Our Participants) Doing in Qualitative Research? International Journal of Drug Policy; 15 pp395–405.

Massey, D. (1994). Space, Place, and Gender. University of Minnesota Press, Minneapolis.

May, T. and Hough, M. (2004). Drug Markets and Distribution Systems. Addiction Research and Theory; 12(6) pp549–563.

McCambridge, J., Witton, J. and Elbourne, D.R. (2014). Systematic Review of the Hawthorne Effect: New Concepts are Needed to Study Research Participation Effects. Journal of Clinical Epidemiology; 67 pp267-277.

McCrady, B.S. and Bux (Jr.), A. (1999). Ethical Issues in Informed Consent With Substance Abusers. Journal of Consulting and Clinical Psychology; 67(2) pp186-193.

McElrath, K. and McElroy, K. (2001). Heroin as Evil: Ecstasy Users' Perceptions About Heroin. Drugs: Education, Prevention and Policy; (8(2) pp177-189.

McGinty, E.E., Kennedy-Hendricks, A. and Barry, C.L. (2019). Stigma of Addiction in the Media. In Avery, J. D. and Avery, J. J. (eds.). The Stigma of Addiction, pp201-211.

McIntosh, J and McKeganey, N. (2002). Beating the Dragon. Routledge, London.

McIntosh, J. and McKeganey, N. (2000). Addicts' Narratives of Recovery from Drug Use: Constructing a Non-Addict Identity. Social Science & Medicine; 50 pp1501-1510.

McIntosh, J. and McKeganey, N. (2001). Identity and Recovery from Dependent Drug Use: The Addict's Perspective. Drugs, Education, Prevention and Policy; 8(1) pp47-59.

McKeganey, N. (2011). Abstinence and Harm Reduction: Can they Work Together? International Journal of Drug Policy 22(3) pp194-195.

McKeganey, N., Bloor, M., McIntosh, J. and Neale, J. (2009). Key Findings from the Drug Outcome Research in Scotland Study; University of Glasgow Centre for Drug Misuse Research - Occasional Paper, pp1-66.

McKeganey, N., Bloor, M., Robertson, M., Neale, J. and MacDougall, J. (2005). Abstinence and Drug Abuse Treatment: Results from the Drug Outcome Research in Scotland Study. Drug Education, Treatment and Policy; 13(6) pp537-550.

McLellan, T. (2010). What is Recovery? Revisiting the Betty Ford Institute Consensus Panel definition: The Betty Ford Consensus Panel and consultants. Journal of Substance Abuse Treatment; 38, pp200-201.

McLellan, T. (2017). Substance Misuse and Substance Use Disorders: Why Do They Matter in Healthcare? Transactions of the American Clinical and Climatological Association; Vol. 128, pp112-130.

McMurran, M. (1994). The Psychology of Addiction. Routledge, London.

Meloni, F. (2020). A Boat Taking on Water: Rethinking Emotions and the Politics of Knowledge in Ethnographic Research with "Hard-To-Reach" and Marginalised Populations. Emotion, Space and Society; 36 pp1-5.

Merleau-Ponty, M. (2004). The World of Perception. Routledge, London.

Merton, R.K. (1969). Social Theory and Social Structure. The Free Press, New York.

Messinger, E. and Zitrin, A. (1965). A Statistical Study of Criminal Drug Addicts: Psychosis, Psychoneurosis, Mental Deficiency, and Personality Types. Crime and Delinquency; 11(3) pp283-292.

Meysamie, A., Sedeghat, M. Mahmoodi, M., Ghodsi, S.M and Eftekhar, B. (2009). Opium Use in a Rural Area of the Islamic Republic of Iran. Eastern Mediterranean Health Journal, 15 (2) pp425-431.

Miller, W.R., Forcehimes, A., O'Leary, M.J. and LaNoue, M.D. (2008). Spiritual Direction in Addiction Treatment: Two Clinical Trials. Journal of Substance Abuse Treatment; 35 pp434–442.

Mlinac, M.E. and Feng, M.C. (2016). Assessment of Activities of Daily Living, Self-Care, and Independence. Neuropsychology; 31(6) pp506–516.

Mold, A. (2007). Illicit Drugs and the Rise of Epidemiology During the 1960s. Journal of Epidemiology and Community Health; 61 pp278–281.

Monnat, S.M. and Rigg, K.K. (2018). The Opioid Crisis in Rural and Small Town America. Carsey School of Public Policy; (Summer) 135 pp1-6.

Monteiro, K., Dumenco, L., Collins, S. Bratberg, J. MacDonnell, C., Jacobson, A., Dollase, R. and George, G. (2017). An Interprofessional Education Workshop to Develop Health Professional Student Opioid Misuse Knowledge, Attitudes, and Skills. Journal of the American Pharmacists Association; 57 pp1513-1517.

Moody, L., Satterwhite, E. and Bickel1, W. K. (2017). Substance Use in Rural Central Appalachia: Current Status and Treatment Considerations. Rural Mental Health; 41(2) pp123–135.

Moore, D. (1993). Ethnography and Illicit Drug Use: Dispatches from an Anthropologist in the "Field". Addiction Research; 1 pp11-25.

Moore, D. (1993). Social Controls, Harm Minimisation and Interactive Outreach: The Public Health Implications of an Ethnography of Drug Use. Australian Journal of Public Health; 17(1) pp58-67.

Moraes, F. (2001). Heroin. Ronin Publishing, California.

Morley, K.I, Feris, J.A., Winstock, A.R. and Lynskey, M.T. (2017). Polysubstance Use and Misuse or Abuse of Prescription Opioid Analgesics: A Multi-Level Analysis of International Data. International Association for the Study of Pain; 158(6) pp1138–1144.

Morton, C.M. (2019). Community Social Deprivation and Availability of Substance Use Treatment and Mutual Aid Recovery Groups. Substance Abuse Treatment, Prevention, and Policy; 14(33) pp1-5.

Moss, H.B., Goldstein, R.B., Cheng, C.M. and Hsiao-Ye, Y. (2016). Patterns of Use of Other Drugs Among Those with Alcohol Dependence: Associations with Drinking Behavior and Psychopathology. Addictive Behaviours; 50 pp192–198.

Mott, J. (1992). Crack and Cocaine Use in England and Wales. Home Office, London.

Moyle, L. and Coomber, R. (2015). Earning a Score: An Exploration of the Nature and Roles of Heroin and Crack Cocaine "User Dealers". British Journal of Criminology; 55 pp534–555.

Murphy, R. (1995). Sociology as if Nature Did Not Matter: An Ecological Critique. The British Journal of Sociology; 46(4) pp688-707.

Murphy, S. and Waldorf, D. (1991). Kickin' Down the Street Doc: Shooting Galleries in the San Francisco Bay Area. Contemporary Drug Problems; 18(9) pp29.

Nahata, R., Mancino, M.J., Thostenson, J.M. and Oliveto, J.M. (2018). Survey of Treatment Preferences for Opioid Use Disorder. Jacobs Journal of Addiction and Therapy; 5(3) pp1-12.

Narcotics Anonymous (1997) The Group Booklet, Revised. AA World Services, U.S.A.

National Geographic Society (2018). Field Work. National Geographic, Society Washington.

National Institute on Drug Abuse (2019). Treatment Approaches for Drug Addiction. Substance Abuse and Mental Health Services administration; pp1-8.

National Records of Scotland (NRS) (2018). Scotland's Population the Registrar General's Annual Review of Demographic Trends. National Records of Scotland, Edinburgh.

National Records of Scotland (NRS) (2021) Drug-Related Deaths in Scotland in 2020. National Records of Scotland, Edinburgh.

National Treatment Agency for Substance Misuse (2006). Models of Care for Treatment of Adult Drug Misusers: Update 2006. National Health Service, London.

Neale, J. (1998). Drug Users' Views of Prescribed Methadone. Drugs: Education, Prevention and Policy; 5(1) pp33-45.

Neale, J. (2001). Homelessness Amongst Drug Users: A Double Jeopardy Explored. International Journal of Drug Policy; 12 pp353–369.

Neale, J., Bloor, M. and McKeganey, D. (2007). How do Heroin Users Spend Their Spare Time? Drugs: Education, Prevention and Policy; 14(3) pp231–246.

Neale, J., Nettleton, S and Pickering, L. (2014). Gender Sameness and Difference in Recovery from Heroin Dependence: A Qualitative Exploration. International Journal of Drug Policy; 25 pp3– 12.

Neale, J., Nettleton, S. and Pickering, L. (2011a). Recovery from Problem Drug Use: What Can We Learn from the Sociologist Erving Goffman? Drugs: Education, Prevention and Policy; 18(1) pp3-9.

Neale, J., Nettleton, S. and Pickering, L. (2011b). What is the Role of Harm Reduction When Drug Users Say They Want Abstinence? International Journal of Drug Policy; 22 pp189–193.

Neale, J., Nettleton, S., and Pickering, L. (2011c). Heroin Users' Views and Experiences of Physical Activity, Sport and Exercise. International Journal of Drug Policy; 23 pp120-127.

Neale, J., Pickering, L. and Nettleton, S. (2012). The Everyday Lives of Recovering Heroin Users. London, Royal Society of Arts.

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Wykes, T. and Strang, J. (2015). "You're All Going to Hate the Word "Recovery" by the End of This": Service Users' Views of Measuring Addiction Recovery. Drugs Education Prevention and Policy; 22(1) pp26–34.

Nehlin, C., Will brand, M., Brander, C.W. and Oster, C. (2020). Overcoming Heroin Addiction without the Use of Pharmaceuticals: A Qualitative Interview Study. Journal of Psychoactive Drugs; 52(3) pp211-217.

Nettleton, S. Neale, J. and Pickering, L. (2011). "I Don't Think There's Much of a Rational Mind in a Drug Addict when they are in the Thick of it"; Towards and Embodied Analysis of Recovering Heroin Users. Sociology of Health and Illness; 33(3) pp341-355.

Nettleton, S. Neale, J. and Pickering, L. (2012). "I Just Want to be Normal": An Analysis of Discourses of Normality Among Recovering Heroin Users. Health; 17(2) pp174–190.

Nettleton, S. Neale, J. and Pickering, L. (2012). Heroin Users' Views and Experiences of Physical Activity, Sport and Exercise. International Journal of Drug Policy; 23 pp120–127.

Newton, L. (2009). Reflexivity, Validity and Roses. Complicity: An International Journal of Complexity and Education; 6(2) pp104-112.

Nguyen, T.T., Luonga, A.N., Nhamb, T.T.T., Chauvinc, C., Feelemyerd, J., Nagote, N., Jarlaisf, D.D., Lea, M.G. and Jauffret-Roustidec, M. (2019). Struggling to Achieve a "Normal Life": A Qualitative Study of Vietnamese Methadone Patients. International Journal of Drug Policy; 68 pp18-26.

Noland, (Jr.) J.L. (2010). Harm Reduction and the American Difference: Drug Treatment and Problem-Solving Courts in Comparative Perspective. Journal of Health Care Law and Policy; 13(1) pp30-47.

Nurani, L.M. (2008). Critical Review of Ethnographic Approach. Journal of Sociotechnology; 14(7) pp441-447.

Nursing and Midwifery Council (2018). The NMC Code of Professional Conduct: The Standard. NMC, London.

Nursing and Midwifery Council. (2015). The Code. N.M.C., London.

Nutt D, (2011). Let Not the Best Be The Enemy of The Good. Addiction; 106 pp1892-1893.

Nyswander, M. (1956). The Drug Addict as a Patient. Grune & Stratton, New York.

O'Donnell, J. (1965). Diffusions of the Intravenous Technique Among Narcotic Addicts in the U.S.; Journal of Health and Social Behavior, 9 pp120-130.

Office for Health Improvements and Disparities (2021). Commons Library Debate Pack. London.

Office for National Statistics (2015). Drug Use, Alcohol and Smoking: Smoking, Drinking and Drug Taking in Great Britain and Associated Deaths and Illness. {Internet} Available at: https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/pages/2/ (Accessed 7th January 2018).

Office for National Statistics (2022). Drug Misuse in England and Wales: Year Ending March 2022. London.

Olsen, W.K. (2008). Realist Ontology and Epistemology for Rural Research. Brooks World Poverty Institute Working Paper; 53 pp1-25.

Orford, J. (2001). Conceptualizing Addiction: Addiction as Excessive Appetite. Addiction; 96 pp15–31.

O' Reilly, K. (2009). Key Concepts in Ethnography. SAGE Publications Limited, London.

O' Reilly, K. (2012). Ethnographic Methods. Routledge, London.

Osgood, D.W. and Chambers, J.M. (2003). Community Correlates of Rural Youth Violence. Faculty Publications of the Center on Children, Families, and the Law; 17 pp1-10.

Oxford English Dictionary (2019). Waite, M. (ed.). Oxford University Press, Oxford.

Padykula and Conklin (2010). "The Self-Regulation Model of Attachment Trauma and Addiction". Clinical Social Work Journal; 38 pp351–360.

Park, R.E. (1915). The City: Suggestions for the Investigation of Human Behavior in the City Environment. American Journal of Sociology; 20(5) pp577-612.

Park, R.E. and Burgess, E.W. (1925). The City. University of Chicago Press, Chicago.

Parker, H., Aldridge, J. and Measham, F. (1998). Illegal Leisure: The Normalisation of Adolescent Recreational Drug Use. Routledge, London.

Parker, H., Bakx, K. and Newcombe, R. (1988). Living with Heroin. Open University Press, Milton Keynes.

Parkin, S. and Coomber, R. (2009). Informal Sorter Houses: A Qualitative Insight of the 'Shooting Gallery' Phenomenon in a UK Setting. Health and Place*;* 15 pp981-89.

Parkin, S. (2013). Habitus and Drug Using Environments: Health, Place and Lived Experience. Ashgate Publications Ltd, Farnham.

Parsa, R.M. and Torabi, Z. (2015). Explaining the Concept of Identity and Sense of Place in Residential Environment and Lifestyle. Kuwait Chapter of the Arabian Journal of Business and Management Review; 4(5) pp27-43.

Parsons, G. (2012). Drug Strategy 2010 - A Panacea for Drug Addicts? The Pharmaceutical Journal; 286 pp12-17.

Pascale, C. (2011). Cartographies of Exploring Knowledge: Exploring Qualitative Epistemologies. SAGE, Los Angeles.

Paulozzi, L.J. and Yongli, X.M. (2008). Recent Changes in Drug Poisoning Mortality in the United States by Urban-Rural Status and by Drug Type. Pharmacoepidemiology And Drug Safety; 17 pp997-1005.

Payne, M. (1997). An Introduction to Barthes, Foucault, and Althusser. Blackwell, Malden.

Pearson, G. (1987). The New Heroin User. Blackwell, Oxford.

Pedlar, M. (2012). Action Learning in Practice. Gower Publishing, Vermont.

Peele, S. (2001). Is Gambling an Addiction Like Drug and Alcohol Addiction? Developing Realistic and Useful Conceptions of Compulsive Gambling. Journal of Gambling Issues; Issue 3.

Peele, S. (1985). The Pleasure Principle in Addiction. Journal of Drug Issues; 15(29) pp193–201.

Peele, S. (1985). The Meaning of Addiction: An Unconventional View. John Wiley, San Francisco.

Peele, S. (1989). Visions of Addiction: Theory, Research and Treatment. Kreiger, Florida.

Peluso, E. and Peluso, L. (1988). Women and Drugs; Getting Hooked and Getting Clean. Compcare Publishers, Minneapolis.

Perretti-Watel, P. (2003). Heroin Users as "Folk Devils" and French Public Attitudes Toward Public Health Policy. The International Journal on Drug Policy; 14(4) pp321-329.

Petteway, R., Mujahid, M. and Allen, A. (2019). Understanding Embodiment in Place-Health Research: Approaches, Limitations, and Opportunities. Journal of Urban Health; 96 pp289–299.

Pfau, H. (2007). To Know Me Now. Qualitative Social Work; 6(4) pp397-410.

Philips, M. (2002). The Production, Symbolization and Socialization of Gentrification: Impressions from Two Berkshire Villages. Transactions of the Institute of British Geographers; 27 pp282-308.

Pittel, S.M. (1971). Drugs and the Adolescent Experience. Journal of Drug Issues; 1(3) pp 215–236.

Pool, R. (2017). The Verification of Ethnographic Data. Ethnography; 18(3) pp281–286.

Pope, C. and May, N. (1995). Qualitative Research: Reaching the Parts Other Methods Cannot Reach: An Introduction to Qualitative Methods in Health and Health Services Research. BMJ; 311 pp42-45.

Preble, E. and Casey, J.J. (1969). Taking Care of Business – The Heroin Users' Life on the Street; International Journal of the Addictions, 4 pp1-4.

Prieto, E. (2012). The Continental Divide: Space, Place, and the Poststructuralist Countersciences. In, Prieto, E, (ed.). Literature, Geography, and the Postmodern Poetics of Place, pp75-106. Palgrave Macmillan, New York.

Public Health Scotland (2021) Detailed Insight into Drug-Related Deaths in Scotland Seeks to Inform Collective Response. {Internet} Available at: https://publichealthscotland.scot/news/2022/july/detailed-insight-into-drug-related-deaths-in-scotland-seeks-to-inform-collective-response/ (Accessed July 28th 2022).

Public Health Scotland (PHS) (2019). Drugs Overview (Scotland). {Internet} Available at: http://www.healthscotland.scot/health-topics/drugs/drugs-overview#:~:text=The%20estimated%20number%20of%20individuals,in%202008%2C%20which%20was%20574. (Accessed June 20th, 2020).

Punch, K. (2005). Introduction to Social Research: Quantitative and Qualitative Approaches. SAGE, London.

Putt, J. and Delahunty, B. (2006). Illicit Drug Use in Rural and Remote Indigenous Communities. Australian Institute of Criminology; No. 322 pp1-6.

Quaglio, G., Lugoboni, F., Pajusco, B., Fornasiero, A., Lechi, A., Mezzelani, P., Pattaro, C. and Jarlais, D.C.D. (2014). Heterosexual Relationships Among Heroin Users in Italy. Drug and Alcohol Dependence; 75 pp207–213.

Radcliffe, P. and Stevens, A. (2008). Are Drug Treatment Services Only for "Thieving Junkie Scumbags"? Drug Users and the Management of Stigmatised Identities. Social Science and Medicine; 67 pp1065-1073.

Radcliffe-Brown, A.R. (1926). Methods in Social Anthropology. University of Chicago Press, Chicago.

Raistrick, D., Tober, G., Sweetman, J., Unsworth, S., Crosby, H., and Evans, T. (2014). Measuring Clinically Significant Outcomes: LDQ, CORE-10, and SSQ as Dimension Measures of Addiction. The Psychiatrist; 38 pp112–115.

Rassool, G.H. (1998). Substance Use and Misuse. Blackwell Publishing, Oxford.

Raymond, F. (1973). Drug Abuse: A Sociological Viewpoint. Arete; 2 pp183-198.

Recovery Research Institute (2019). Heroin. {Internet} Available at: https://www.recoveryanswers.org/research-post/long-term-treatment-outcomes-for-individuals-with-opioid-use-disorders/ (Accessed 13th August 2019).

Redko, C., Rapp, R.C. and Carlson, R.G. (2006). Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users. Journal of Drug Issues; 36(4) pp831–852.

Redlinger, L.J. (1975). Marketing and Distributing Heroin: Some Sociological Observations. Journal of Psychedelic Drugs; 7(4) pp331-337.

Reinarman, C. (2005). Addiction as Accomplishment: The Discursive Construction of Disease. Addiction Research and Theory August; 13(4) pp307–320.

Reith, G. (2004). Consumption and its Discontents: Addiction, Identity and the Problems of Freedom. The British Journal of Sociology; 55(2) pp283-300.

Relph, E. (1976). Place and Placelessness. Pion, London.

Relph, E. (1991). Post-Modern Geography: The Canadian Geographer; 35 pp98-105.

Reinharz, S. (2017) On Becoming a Social Scientist From Survey Research and Participant Observation to Experiential Analysis. Routledge, London.

Reuters, P. and Stevens, A. (2007). An Analysis of UK Drug Policy A Monograph Prepared for the UK Drug Policy Commission. UK Drug Policy Commission, London.

Rhodes, T ., Kimber, J., Small, W., Fitzgerald, J. Kerr, T., Hickman, T. and Holloway, G. (2006). Public Injecting and the Need for 'Safer Environment Interventions' in the Reduction of Drug-Related Harm. Addiction; 101(10) pp1384-93.

Rhodes, T. and Moore, D. (2001). On the Qualitative in Drugs Research. Addiction Research and Theory; 9(4) pp279-297.

Rhodes, T. and Moore, D. (2001). On the Qualitative in Drugs Research: Part Two. Addiction Research and Theory; 9(6) pp515-517.

Richards, A. (1932). Hunger and Work in a Savage Tribe: A Functional Study of Nutrition Among the Southern Bantu. Routledge & Kegan Paul, London.

Richardson, W. (2018). Norwegian Drug Addicts (Oslo). {Internet} Available at: https://www.warrenrichardson.com/drug-addicts (Accessed 3rd November 2020).

Ritter, A. and Cameron, J. (2006). A Review of the Efficacy and Effectiveness of Harm Reduction Strategies for Alcohol, Tobacco and Illicit Drugs. Drug and Alcohol Review; 25(6) pp611-624.

Robertson, E.B., Sloboda, Z., Boyd, G.M., Beatty, L. and Kozel, N.J. (1997). Rural Substance Abuse: State of Knowledge and Issues. NIDA Research Monograph No. 168. pp90–130. U.S. Department of Health and Human Services (DHHS). U.S. Government Printing Office, Washington, DC:

Robin, L.N. (1980). Natural History of Drug Abuse. Acta Psychiatrica Scandanavia; 62(284) pp7-20.

Robins L. N. (1993). Vietnam Veterans' Rapid Recovery from Heroin Addiction: A Fluke or Normal Expectation? Addiction; 88 pp1041–54.

Robson, P. (2002). Forbidden Drugs; Oxford University Press, Oxford.

Rodman, M.C. (1992). Empowering Place: Multilocality and Multivocality. American Anthropologist; 94 (3) pp640-656.

Roe, B., Beyon, C. Pickering, L. and Duffy, P. (2010). Experiences of Drug Use and Ageing: Health, Quality of Life, Relationship and Service Implications. Journal of Advanced Nursing; 66(9) pp1968–1979.

Rolleston Committee (1926). Rolleston Report: Report of the Departmental Committee on Morphine and Heroin Addiction. Ministry of Health, London.

Rosenbaum, M. (1981). Women Addicts' Experience of the Heroin World. Urban Life; 10 pp65-91.

Rosenbaum, M. (1981). Women on Heroin. Rutgers University Press. New Jersey.

Rosenthal, R.J. and Faris, S. (2019). The Etymology and Early History of "Addiction". Addiction Research and Theory; 27(2) pp1-13.

Rozanova, J., Marcus, R., Taxman, F.S., Bojko, M.J., Madden, L. Farnum, S.O., Mazhnaya, A., Dvoriak, S. and Altice1, F.L. (2017). Why People Who Inject Drugs Voluntarily Transition Off Methadone in Ukraine. Qualitative Health Research; 27(13) pp2057–2070.

Russon, J. (1994). Embodiment and Responsibility: Merleau-Ponty and the Ontology of Nature. Man, and World; 27 pp291-308.

Ryan, G. (2017). Introduction to Positivism, Interpretivism and Critical Theory. Nurse Researcher; 25(4) pp14-20.

Sack, R. D. (1997). Homo-Geographicus. Johns Hopkins University Press, Baltimore.

Said, E.W. (1993). Culture and Imperialism. Vintage Books, New York.

Saldana, J. (2011). Fundamentals of Qualitative Research. Oxford University Press, Oxford.

Saleme, D.M., Kluwe-Schiavon, B., Soliman, A., Misiak, B., Frydecka, D. and Moustafa, A.A. (2018). Factors Underlying Risk Taking in Heroin-Dependent Individuals: Feedback Processing and Environmental Contingencies. Behavioural Brain Research; 350 pp23-30.

Salmon, R. and Salmon, S. (1977). The Causes of Heroin Addiction- A Review of the Literature. Part II. The International Journal of the Addictions; 12(7) pp937-951.

Salzman, P.C. (2002). On Reflexivity. American Anthropologist; 104(3) pp805-813.

Sana Loue, J.D. and Ioan, B. (2007). Legal and Ethical Issues in Heroin Diagnosis, Treatment, and Research. The Journal of Legal Medicine; 28(2) pp193-221.

Sanderson, D. and Polson, R. (1942). Rural Sociology and Rural Social Organisation. John Wiley, New York.

Santos, S.M. Chor, D. Werneck, G.L. (2010). Demarcation of Local Neighborhoods to Study Relations Between Contextual Factors and Health. International Journal of Health Geographics; 9(34) pp1-15.

Schatzman, L and Strauss, A.L. (1973) Field Research: Strategies for a Natural Sociology. Prentice-Hall, New Jersey.

Scheibe, A., Shelly, S., Versfeld, A., Howell, S. and Marks, M. (2017). Safe Treatment and Treatment of Safety: Call for a Harm-Reduction Approach to Drug-Use Disorders in South Africa. South African Health Review; 20 pp197–204.

Scherbaum, N. and Speka, M. (2008). Factors Influencing the Course of Opiate Addiction. International Journal of Methods in Psychiatric Research; 17(1) pp39–S44.

Schilling, R.F., El-Bassel, N., Gilbert, L. and Schinke, S.P. (1991). Correlates of Drug Use, Sexual Behavior, and Attitudes toward Safer Sex among African American and Hispanic Women in Methadone Maintenance. Journal of Drug Issues; 21(4) pp685-698.

Schneider, K.E., O'Rourke, A., White, R.H., Park, J.N., Musci R.J., Kilkenny, M.E., Sherman, S.G. and Allen, S.T. (2020). Polysubstance Use in Rural West Virginia: Associations Between Latent Classes of Drug Use, Overdose, and Take-Home Naloxone. International Journal of Drug Policy; 76 pp1-14.

Schuckit, M. A. (2016). Treatment of Opioid-Use Disorders. New England Journal of Medicine; 375(4) pp357-368.

Scottish Drug Misuse Database (2019). Drug Misuse. {Internet} Available at: https://www.isdscotland.org/Health-topics/Drugs-and-alcohol-misuse/Drugs-misuse/Scottish-Drug-Misuse-Database/ (Accessed September 13th 2020).

Scottish Drugs Forum (2007). Drugs and Poverty: A Literature Review. SAADAT, Glasgow.

Scottish Executive (2006). Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland. Scottish Executive, Edinburgh.

Scottish Government (2008). The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem. Scottish Government, Edinburgh.

Scottish Government (2015). Rural Scotland Key Facts 2015- People Communities Services and Lifestyle Economy and Enterprise. Scottish Government, Edinburgh.

Scottish Government (2020). Drug-related deaths in Scotland in 2019. National Records of Scotland, Edinburgh.

Scottish Government (2018). Rural Scotland Key Facts 2018- People Communities Services and Lifestyle Economy and Enterprise. Scottish Government, Edinburgh.

Scully, J.L. (2004). What is a Disease? European Molecular Biology Organization; 5(7) pp650-653.

Serres, M. (1995). Genesis. The University of Michigan Press, U.S.A.

Shadur, J. and Hussong, A. (2014). Friendship Intimacy, Close Friend Drug Use, and Self-Medication in Adolescence. The Journal of Social and Personal Relationships; 31(8) pp997-1018.

Sharpe, G. (2015). Precarious Identities: "Young" Motherhood, Desistance and Stigma. Criminology & Criminal Justice; 15(4) pp407–422.

Sharroff, R.L. (1969). Character Problems and Their Relationship to Drug Abuse. The American Journal of Psychoanalysis; 29(2) pp186–193.

Sherman, S. G., Hua, W. and Latkin, C. A. (2004). Individual and Environmental Factors Related to Quitting Heroin Injection. Substance Use & Misuse; 39(8) pp1199-1214.

Shewan, D. and Dalgarno, P. (2005). Evidence for Controlled Heroin Use? Low Levels of Negative Health and Social Outcomes Among Non-Treatment Heroin Users in Glasgow. British Journal of Health Psychology; 10 pp33-48.

Shields, R. (2006). Knowing Space. Theory, Culture & Society; 23 (2-3) pp146-149.

Short, J.F. (2002). Criminology, the Chicago School, and Sociological Theory. Crime Law and Social Change; 37 pp107-115.

Shucksmith, M. and Brown, D.L. (2016). Routledge International Handbook of Rural Studies. Routledge, London.

Siegel, S. and Ramos, B.M.C. (2002). Applying Laboratory Research: Drug Anticipation and the Treatment of Drug Addiction. Experimental and Clinical Psychopharmacology; 10(3) pp162–183.

Silverman, D. (ed.). (2019). Qualitative Research. SAGE, Los Angeles.

Singer, M. (2011). Anthropology and Addiction: An Historical Review. Addiction; 107 pp1747–1755.

Singer, M. (2012). Anthropology and Addiction: An Historical Review; Addiction, 107(10) pp1747-1755.

Singer, M. and Page, J.B. (2014). The Social Value of Drug Addicts: Uses of the Useless. Routledge, New York.

Single, E. (1995). Defining Harm Reduction. Drug and Alcohol Review; 14(3) pp287-290.

Sington, D. (1966). Psychosocial Aspects of drug Taking. Pergamon Press, Oxford.

Skogan, W.G. (1990). Disorder and Decline: Crime and the Spiral of Decay in American Neighborhoods. University of California Press, Berkley.

Smith, C. (2014). Injecting Drug Use and the Performance of Rural Femininity: An Ethnographic Study of Female Injecting Drug Users in Rural North Wales. Critical Criminology; 22 pp511-525.

Smith, D. (1988). The Chicago School: A Liberal Critique of Capitalism. St Martin's Press, New York.

Smith, N. (1984). Uneven Development. Blackwell, Oxford.

Sobell, L., Sobell, M. and Toneatto, T. (1992). Recovery from Alcohol Problems with Treatment. In Heather, N., Miller, W.R. and Greeley, J. M. Self-Control and the Addictive Behaviors. Macmillan, New York.

Solecki, W.D. and Welch, J.M. (1995). Urban Parks: Green Spaces or Green Walls? Landscape and Urban Planning; 32 pp93-106.

South, N. (ed.). (1999). Drugs: Cultures, Controls and Everyday Life. SAGE, London.

Soverow, G., Rosenberg, C.M. and Ferneau, M.A. (1972). Attitudes Towards Drug and Alcohol Addiction: Patients and Staff. British Journal of Addiction; 67 pp195-198.

Spear, H. B. (1969). The Growth of Heroin Addiction in the United Kingdom. British Journal of Addiction; 64 pp245-255.

Specialist Drug and Alcohol Service (2018). Unit Philosophy. NHS Dumfries and Galloway, Dumfries.

Sporer, K. A. (2003). Strategies for Preventing Heroin Overdose. British Medical Journal; 326 pp442-444.

Spradley, J.S. (2016). Participant Observation. Waveland Press, Illinois.

Stallwitz, A. (2012). The Role of Community-Mindedness in the Self-Regulation of Drug Cultures. Springer, Germany.

Stallwitz, A. and Shewn, D. (2004). A Qualitative Exploration of the Impact of Cultural and Social Factors on Heroin Use in Shetland (Scotland). Journal of Psychoactive Drugs; 36(3) pp367-378.

Steele, F. (1981). The Sense of Place. CBI Publishing Company, U.S.A.

Stefanovic, I. (1998). Phenomenological Encounters with Place: Cavtat to Square One. Journal of Environmental Psychology; 18(1) pp33-44.

Steger, M.B. and Roy, R.K. (2010). Neoliberalism: A Very Short Introduction. Oxford University Press, Oxford.

Stein, M.D. Anderson, B.J. and Bailey, G.L. (2017). Broken Lives: Fights, Fractures, and Motor Vehicle Accidents Among Heroin Users Entering Detoxification. Drug and Alcohol Dependence; 177 pp194-198.

Steiner, A. and Teasdale, S. (2019). Unlocking the Potential for Rural Social Enterprise. Journal of Rural Studies; 70 pp144-155.

Stephens, R.C. (1985). The Sociocultural View of Heroin Use: Toward a Role Theoretical Model. Journal of Drug Issues; (Fall) pp433-446.

Stephens, R.C. (1991). The Street Addict Role. State University New York Press, Albany.

Stevens, A. (2010). Drugs, Crime and Public Health. The Political Economy of Drug Policy. Routledge, London.

Stewart, K. (1996). A Space on the Side of the Road; Cultural poetics in an "Other America". Princeton University Press, Princeton.

Stimson, G. V. (1998). Harm Reduction in Action: Putting Theory into Practice. International Journal of Drug Policy; 9 pp401–409.

Stimson, G. V. and Oppenheimer, E. (1982). Heroin Addiction: Treatment and Control in Britain. Tavistock, London.

Stone, E. and Fletcher, K. (2003). User Views on Supervised Methadone consumption. Addiction Biology; 8 pp45 – 48.

Strang, J. and Gossop, M. (2005). Heroin. Addiction and the British System Vol 1: Origins and Evolution. Routledge, Oxon.

Strang, J., Groshkova, T., Uchtenhagen, A., Brink, W.V.D., Haasen, C., Schecter, M.T., Lintzeris, N., Bell, J., Pirona, A., Oviedo-Joekes, E., Simon, R. and Metrebian, N. (2016). Heroin on Trial: Systematic Review and Meta-Analysis of Randomised Trials of Diamorphine-Prescribing as Treatment for Refractory Heroin Addiction. British Journal of Psychiatry; 207 pp5–14.

Strang, S., Sheridan, J., Hunt, C., Kerr, B., Gerada, C. and Pringle, M. (2005). The Prescribing of Methadone and Other Opioids to Addicts: National Survey of GPs in England and Wales. British Journal of General Practice; 55(515) pp444–451.

Sun, A., Chen, Y. and Marsiglia, F. (2016). Trauma and Chinese Heroin Users. Journal of Ethnicity in Substance Abuse; 15(2) pp144-159.

Sussman, S. and Sussman, A. N. (2011). Considering the Definition of Addiction. International Journal Environmental Research and Public Health; 8 pp4025-4038.

Sutter, A. (1969). The World of the Righteous Dope Fiend. Issues in Criminology; 2(2) pp177-222.

Sutton, M. (1995). Supply by Theft: Does the Market for Second-hand Goods Play a Role in Keeping Crime Figures High? British Journal of Criminology; 35(3) pp400-416.

Szasz, T. (1972). The Myth of Mental Illness - Foundations of a Theory of Personal Conduct. Paladin Press, U.S.

Szasz, T. (1974). The Ethics of Addiction. Journal of Drug Issues; 2(1) pp42-49.

Szasz, T. (1975). Ceremonial Chemistry: The Ritual Persecution of Drugs Addicts and Pushers. Routledge and Kegan Paul LTD, London.

Szott, K. (2020). "Heroin is the Devil": Addiction, Religion, and Needle Exchange in the Rural United States. Critical Public Health; 30(1) pp68-78.

Taylor, A. (1994). Women Drug Users: An Ethnography of a Female Injecting Community. Clarendon Press, New York.

Taylor, I., Walton, P. and Young, J. (1973). The New Criminology: For a Social Theory of Deviance. Routledge, London.

Telfer, I. and Clulow, C. (1990). Heroin Misusers: What They Think of Their General Practitioners. British Journal of Addiction; 85 pp137-140.

Terry, L. and Cardwell, V. (2015). Understanding the Whole Person: Part One of a Series of Literature Reviews on Severe and Multiple Disadvantages. Revolving Doors Agency, London.

Tesch, R. (1990) Qualitative research: Analysis types and software tools. Falmer, New York.

Thalbourne, M.A. and Houran, J. (2004). Patterns of Self-Reported Happiness and Substance Use in the Context of Transliminality. Personality and Individual Differences; 38 pp327–336.

The National Records of Scotland (NRS) (2018). Scottish Government Urban Rural Classification2018. {Internet} Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking (Accessed 30th of May 2016).

The National Records of Scotland (NRS) (2019). Drug-related Deaths in Scotland in 2019. Edinburgh

Thomas, J. (1983). Toward a Critical Ethnography: A Re-examination of the Chicago Legacy. Urban Life; 11(4) pp477-490.

Thomas, W. I. and Znaniecki, F. (1918). The Polish Peasant in Europe and America. Graham Press, Boston.

Thrift, N. (2006). Space. Theory, Culture & Society; 23(2–3) pp139.

Tomasi, L. (1998). The Tradition of the Chicago School of Sociology. Routledge, New York.

Trimpey, J. (1996). Rational Recovery: The New Cure for Substance Addiction. Pocket Books, New York.

Tuan, Y. (1976) Space and Place: The Perspective of Experience. University of Minnesota Press, Minnesota.

Tucker, S. (2015). Rural Crime and Policing. Universities Police Science Institute; pp1-15.

Tweed, E. and Rodgers, M. (2016). “Taking Away the Chaos”: The Health Needs of People who Inject Drugs in Public Places in Glasgow City Centre. NHS Greater Glasgow and Clyde, Glasgow.

UK Drug Policy Commission. (2008). A Vision of Recovery; UKDPC Recovery Consensus Group, United Kingdom.

UK Drug Policy Commission. (2010). Getting Serious About Stigma: The Problem with Stigmatising Drug Users: An Overview. {Internet}, Available at: https://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf (Accessed 26th of December 2023).

United Kingdom Drug Policy Commission (2008). The UK Drug Policy Commission Recovery Consensus Group. {Internet} Available at: http://www.ukdpc.org.uk/wpcontent/uploads/Policy%20report%20%20A%20vision%20of%20recovery_%20UKDPC%20recovery%20consensus%20group.pdf (Accessed 23rd July 2020).

United Kingdom Focal Point on Drugs (2017). Focal Point Data Tables. {Internet}, Available at: https://www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report (Accessed 21st April 2020).

United Nations Office on Drugs and Crime (2012). World Drug Report. United Nations, New York.

Urry, J. (2004). The Sociology of Space and Place; In Blau, J.R. (Ed). The Blackwell Companion to Sociology. Wiley- Blackwell, Oxford.

U.S. Department of Health and Human Services (HHS) (2016). Office of the Surgeon General, Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Washington, D.C.

U.S. Department of Labor. Bureau of Labor Statistics, (2020). BLS Handbook of Methods. Washington.

Vaillant, G.E. (1969). The Natural History of Urban Narcotic Drug Addiction- Some Determinants; pp341-361, In H. Steinberg (ed.). Scientific Basis of Drug Dependence (J. and A. Churchill, London).

Valentine, P. (2011). Peer-Based Recovery Support Services within a Recovery Community Organisation. In J.F. Kelly and W.L. White, Addiction Recovery Management Theory, Research and Practice. Springer, New York.

Van Ameijdan, E. Langendam, M.W. and Coutinho, R.A. (1999). Continuing Injecting Risk Behaviour: Results from the Amsterdam Cohort Study of Drug Users. Addiction; 94(7) pp1051-61.

Van Maanen, J. (2011). Ethnography as Work: Some Rules of Engagement. Journal of Management Studies; 48 pp218-234.

Van Zee, A. (2009). The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy. Health Policy and Ethics; 99(2) pp221-227.

Verd, J.M., Barranco, O. and Lozares, C. (2020). Blending the Focused Ethnographic Method and Case Study Research: Implications Regarding Case Selection and Generalization of Results. Field Methods; 33(1) pp25-41.

Vosburg, S. K., Eaton, T. A., Sokolowskac, M., Osgood, E. D., Ashworth, J. B., Trudeau, J.J., Muffett-Lipinski, M. and Katz, N.P. (2016). Prescription Opioid Abuse, Prescription Opioid Addiction, and Heroin Abuse Among Adolescents in a Recovery High School: A Pilot Study. Journal of Child & Adolescent Substance Abuse; 25(2) pp105-112.

Wacquant, L. (2008). Relocating Gentrification: The Working Class, Science and the State in Recent Urban Research. International Journal of Urban and Regional Research; 32(1) pp198–205.

Walcher, S., Koc, J., Reichel, V., Schlote, F., Verthein, U. and Reimer, J. (2016). The Opiate Dosage Adequacy Scale for Identification of the Right Methadone Dose - a Prospective Cohort Study. BMC Pharmacology and Toxicology; 17(15) pp1-8.

Waldorf, D. (1970). Life Without Heroin: Some Social Adjustments During Long-Term Periods of Voluntary Abstention. Social Problems; 18 (Fall).

Waldorf, D. and Biernacki, P. (1979). Natural Recovery from Heroin Addiction: A Review of the Incidence Literature. Journal of Drug Issues; 9 pp281-283.

Waldorf, D. (1983). Natural Recovery from Opiate Addiction: Some Social–Psychological Process of Untreated Recovery. Journal of Drug Issues; 13 (Spring) pp237–280.

Waldorf, D. and Biernacki, D. (1981). Natural Recovery from Opiate Addiction: Some Preliminary Findings. Journal of Drug Issues; 11 pp61–74.

Waldorf, D., Reinarman, C. and Murphy, S. (1991). Cocaine Changes: The Experience of Using and Quitting. Temple University, Philadelphia.

Walker, D. and Myrick, F (2006). Grounded Theory: An Exploration of Process and Procedure. Qualitative Health Research; 16(4) pp547-559.

Wanigaratne, S., Wallace, W., Pullin, J., Keaney, F. and Farmer, R. (2006). Relapse Prevention for Addictive Behaviours: A Manual for Therapists. Blackwell Publishing, Oxford.

Warburton, H. Turnbull, P.J. and Hough, M. (2005). Users' Perceptions of Occasional and Controlled Heroin Use. Joseph Rowntree Foundation, London.

Watson, l. and Parke, A. (2011). Experience of Recovery for Female Heroin Addicts: An Interpretative Phenomenological Analysis. International Journal of Mental Health Addiction; 9 pp102–117.

Wacquant, L. (2005) Habitus. International Encyclopaedia of Economic Sociology. (ed.) Becket, J. and Milan, Z. London, Routledge.

Webb, J., Schirato, T. and Danaher, G. (2002). Understanding Bourdieu. Allen and Unwin, Australia.

Weber, M. (1904). The Protestant Ethic and the Spirit of Capitalism. Germany. Translated by Parsons, T. (1950), Charles Scribner and Sons, New York.

Weinberg, D. (2000). "Out There": The Ecology of Addiction in Drug Abuse Treatment Discourse. Social Problems; 47(4) pp606-621.

Weinberg, D. (2002). On the Embodiment of Addiction. Body and Society 8(4) pp1-19.

Weinberg, D. (2011). Sociological Perspectives on Addiction. Sociology Compass; 5(4) pp298-310.

Weinberg, D. (2022). The Particularity of Freedom and Recovery from Addiction in Practice: On the Therapeutic Limitations of Generalising Addiction Science. International Journal of Drug Policy; 107, pp1-7.

Weinstock, J., Barry, D. and Petry, N.M. (2008). Exercise-related Activities are Associated with Positive Outcome in Contingency Management Treatment for Substance Use Disorders. Journal of Addictive Behaviours; 33(8) pp1072-1075.

Weisman, I. (1972). Addiction Control: Myths from Abroad. Journal of Drug Issues; 2 (4) pp61.

Wells, L.E. and Weisshet, R.A. (2004). Patterns of rural and Urban Crime: A Country-Level Comparison. Criminal Justice Review; 29(1) pp1-22.

West, R. (2006). Theory of Addiction; Blackwell Press, Oxford.

Westholm, E. (2008). What Do You Mean by Countryside? In Johansson, B. (ed.). Should all Sweden live? pp49-58; Formas, Stockholm.

White, W. L. (1998). Slaying the Dragon: The History of Addiction Treatment and Recovery in America. Bloomington, IL: Chestnut Health Systems.

White, W. L. (2000). The History of Recovered People as Wounded Healers: I. From Native America to the Rise of the Modern Alcoholism Movement. Alcoholism Treatment Quarterly; 18(1) pp1-23.

White, W. L. (2004). Recovery: The Next Frontier. Counselor; 5(1) pp18-21.

White, W. L. (2005). Recovery: Its History and Renaissance as an Organizing Construct Concerning Alcohol and Other Drug Problems. Alcoholism Treatment Quarterly; 23(1) pp 3-15.

White, W. L. (2007). Addiction Recovery: Its Definition and Conceptual Boundaries. Journal of Substance Abuse Treatment; 33 pp229-241.

White, W. L. (2007). Peer-based Recovery Support Systems. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental.

White, W. L. and Kurtz, E. (2006). The Varieties of Recovery Experience. International Journal of Self Help and Self-Care; 3(1-2) pp21-61.

White, W.L. and Mojer-Torres, L. (2010). Recovery-Orientated Methadone Maintenance. Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center, U.S.A.

Whitehead, T.L. (2005). What is Ethnography? Methodological, Ontological, and Epistemological Attributes. Cultural Ecology of Health Change; pp1-24.

Wikler, A. (1965). Conditioning Factors in Opiate Addiction and Relapse. In D. I. Wilner and G. G. Kassenbaum (eds.). Narcotics. New York: McGraw-Hill.

Wilbank, W. (1989). The Danger in Viewing Addicts as Victims: A Critique of The Disease Model of Addiction. Criminal Justice Policy Review; 4(89) pp407-422.

Williams, J.R. (2008). The Declaration of Helsinki and Public Health. Bulletin of the World Health Organization; pp1-4.

Wincup, E. (2016). More Carrots, Less Sticks: The Role of Incentives in Drug Treatment. Addiction; 112 pp76.

Winick, C. (1962). Maturing out of Narcotic Addiction. Bulletin on Narcotics, 14, pp1-7.

Winship, G. (2016). A Meta-recovery Framework: Positioning the “New Recovery” Movement and Other Recovery Approaches. Journal of Psychiatric and Mental Health Nursing; 23 (1) pp 66-73.

Winship, G. (2014). A Brief History of Addictions Treatment in the UK. Austin Journal of Drug Abuse and Addiction; 1(1) pp1-7.

Winters, P. Davis, B. and Carletto, G. (2009). Assets, Activities and Rural Income Generation: Evidence from a Multi-country Analysis. World Development; 37(9) pp1435–1452.

Witbrodt, J., Kaskutas, L.A. and Grella, C.E. (2015). How do Recovery Definitions Distinguish Recovering Individuals? Five Typologies. Drug and Alcohol Dependence; 148 pp109-117.

Wolcott, H.F. (1987). On Ethnographic Intent. In, Spindler, G and Spindler, L. (eds.). Interpretive Ethnography of Education: At Home and Abroad. Erlbaum, New Jersey.

Wright-Mills, C. (1959). The Sociological Imagination. Oxford University Press, London.

Yang, L., Wong, L.Y., Grivel, M.M. and Hasin, D. S. (2017). Current Opinion Psychiatry; 30(5) pp378–388.

Yates, R. and Malloch, M. (2010). Tackling Addiction: Pathways to Recovery. Jessica Kingsley Publishers, London.

Yearby, R. and Brennan, D.L. (2018). Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism. The American Journal of Economics and Sociology; 77 (3-4) pp1113-1152.

Young, A. M. and Havens, J.R. (2011). Transition From First Illicit Drug Use to First Injection Drug Use Among Rural Appalachian Drug Users: A Cross-Sectional Comparison and Retrospective Survival Analysis. Addiction; 107 pp587-596.

Young, A.M., Havens, J.R. and Leukefeld, C.G. (2010). Route of Administration for Illicit Prescription Opioids: A Comparison of Rural and Urban Drug Users. Harm Reduction Journal; 7 (24) pp1-7.

Zimmering, P., Toolan, J., Safrin, S. and Wortis, S.B. (1951). Heroin Addiction and Adolescent Boys. The Journal of Nervous and Mental Disease; 114 (1) pp19-34.

Zinberg, N.E. (1984). Drug, Set and Setting: The Basis for Controlled Intoxicant Use. University Press, London.

Zobenica, A.J. (2019). Addiction: Disease and/or Social Construct. Sociological Review; 53 (1) pp 233–253.

Zografos, C. (2007). Rurality Discourses and the Role of the Social Enterprise in Regenerating Rural Scotland. Journal of Rural Studies; 23 pp38–51.

Zorbaugh, H.W. (1929). The Gold Coast and the Slum. University of Chicago Press, Chicago.

Appendices

Appendix 1: Participants File.

Name. **pseudonym**	Gender.	Age	No. meetings	Status	Area
Deek	Male	48	Multiple	Key	Dumfries
Charlie	M	54	2		Dumfries
Linsey	Female	34	1		Nithsdale
Michael	M	32	1		Stewartry
Paul	M	42	1		Dumfries
Harold	M	45	1		Dumfries
Kevin	M	42	1		Dumfries
Lee	M	45	1		Annandale
John	M	40	1		Dumfries
Kenny	M	41	1		Dumfries
Alison	F	38	1		Dumfries
Melissa A	F	27	2		Stewartry
David	M	32	1		Wigtownshire
Allan	M	38	1		Lockerbie
Mark	M	44	Multiple		Dumfries
Billy	M	59	Multiple	Key	Dumfries
Melissa B	F	31	1		Dumfries
Richard	M	46	2		Dumfries
Neil	M	37	2		Dumfries
Steven	M	43	1		Dumfries
Claire	F	36	1		Dumfries
Charmaine	F	47	1		Dumfries
Ziggy	M	47	2		Dumfries
Damian	M	22	1		Wigtownshire
Ryan	M	34	1		Dumfries
Kenny	M	48	1		Dumfries
Kyle	M	29	1		Dumfries
Rhonda	F	29	3 - Imprisoned	Key	Nithsdale
Brian	M	29	3 - Imprisoned	Key	Nithsdale
Daniel	M	38	Multiple		Stewartry
Derek	M	38	1		Stewartry
Austin	M	48	1		Stewartry
Ashley	F	30	2		Stewartry
Angela	F	45	1		Annandale
Jack	M	46	1		Annandale
Bonnie	F	36	1		Stranraer
Mark (skip)	F	30	1		Annandale
Francis	F	39	1		Annandale
Rebecca	F	28	1		Annandale
Scott	M	37	1		Annandale
Siobhan	F	28	1		Annandale
Wayne	M	43	2		Annandale

Louise	F	39	2		Annandale
Wullie	M	42	Multiple		Wigtownshire
Josh	M	23	Telephone/several DNA		Wigtownshire
Nikki	F	37	Multiple	Key	Annandale
James	M	37	2		Wigtownshire
Jimmy	M	63	1		Dumfries
Daniel	M	37	1		Dumfries
Ryan	M	35	2		Dumfries
Worker.				**Role.**	**Area covered.**
Gordon	M	36	Several	RMN	Dumfries
Debbie	F	34	Several	RMN	Dumfries
Gemma	F	28	Several	RMN	Nithsdale
Jade	F	28	Several	RMN	Dumfries
Jenny	F	34	Several	RMN	Stewartry
Lynn	F	45	Several	RMN	Annandale
Eileen	F	55	Several	RMN (Manager)	Dumfries SDAS
Jody and Sam	F	26/23	Several	Reception team	Dumfries SDAS
Justin	M	45	Several	RMN (Team lead)	Dumfries SDAS
Lewis	M	34	Several	RMN	Stewartry
Brian	M	58	several	RMN	Dumfries
John	M	55	Several	Needle exchange	All region
Stuart	M	33	1	RMN	Dumfries
Lucy	F	34	Several	OT Assistant	All region
Yvonne	F	?40s	1	Add-action	Dumfries
Garry	M	42	Several	RMN	Wigtownshire
Lisa	F	48	Several	RGN	Wigtownshire
Tony	M	46	1	Homeless officer for Dumfries and Galloway	Dumfries
Emma	F	? 30s	2	RMN (Former addictions nurse Glasgow)	Dumfries

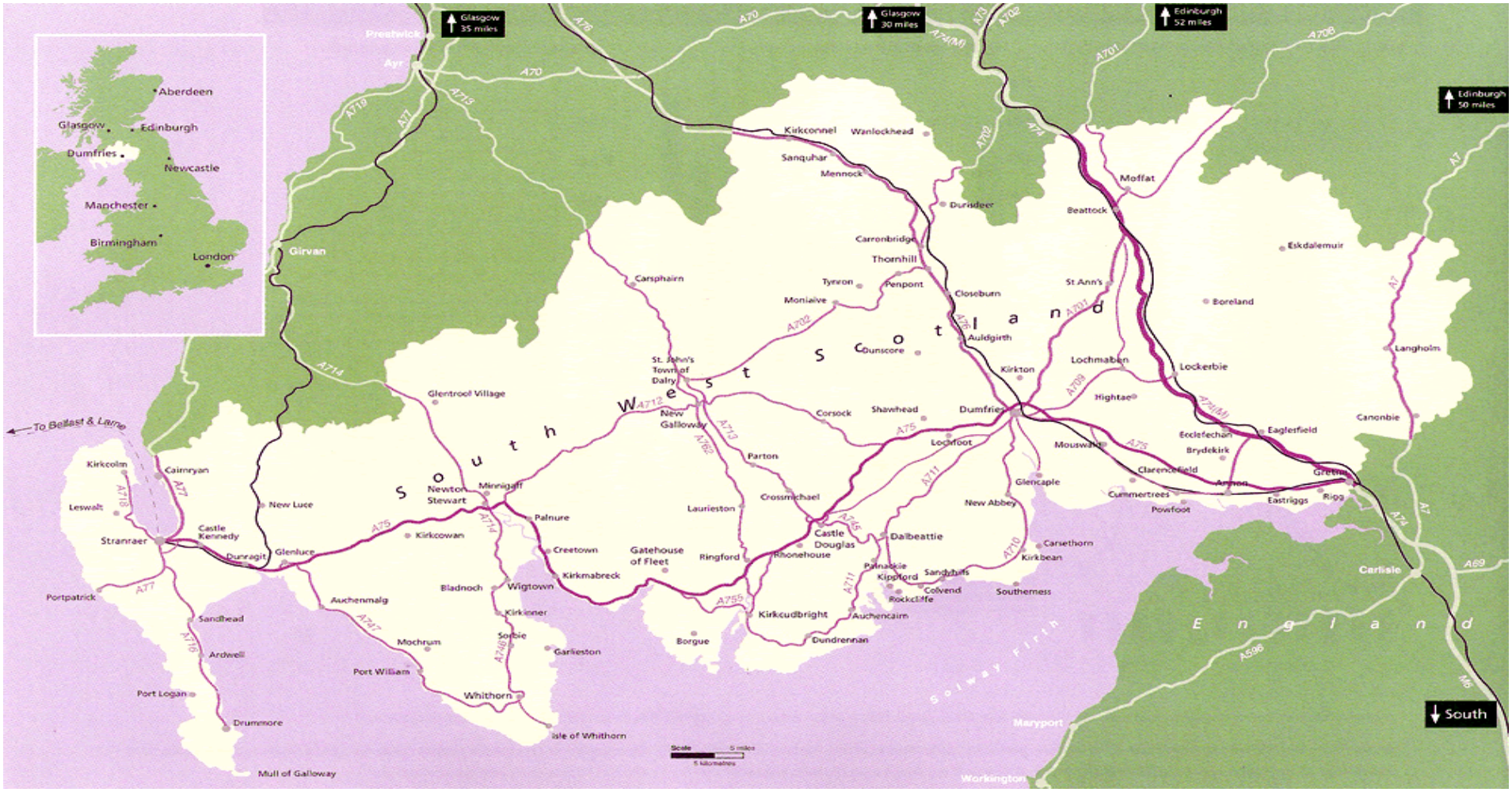
Legend= m- male: f –female

Appendix 2: Translation and Glossary of Terms.

A'll - I will	Lettur- letter
Aboot - about	Maist (maistley)- most
Aes – me	Ma – mother
Ae - of	Ma -my
Alaine - alone	Masel – myself
Ane – own	Metter – matter
Apairt- apart	Muckin aboot –having fun
Auld - old	Moarnin – morning
Aw – all	Nae -no
Aw the gither – altogether	Nivur – never
Awey – away	Nixt –next
Baith - both	Noo - now
Benzo/s – benzodiazepines	O.D.- to overdose on drugs
Boab – money (coins)	Oan- on
Boax – box	Oaff - off
Brutha- brother	Ony- any
Burd – bird; women (romantically)	Oor- our
Caird/s – card/s (plural refers to playing cards)	Oot - out
Cairry – carry	Ower – over
Cannae – cannot	Perty – party
Chinge- change	Pey/ed/s- pay/ paid/pays
Coonted - counted	Pregabs - pregabalin
Coup/cowp (couping)- to overdose	Rar – Stranraer (town of)
Dae – do	Rattlin – withdrawal symptoms
Dinnae – do not	Roofur – roofer, roofing specialist
Doley - unemployed	Roond -round
Er/s – there/ is	Sais- says
Erse – arse	Sare - sore
Ey'wis - always	Selt - sold
Fae – from	Soarted- sorted
Family- family	Stey- stay.
Foond – found	Stoap - stop.
Gaun- go, going	Stupit – stupid
Gid - good	Sumhin – something
Gie –give	Tae - to
Gies a kickin" – sustain physical violence	Thit- that
Gimme – give me	Thum/thame – them
Git – get	Thur- their
Glesga – Glasgow	Toon – town
Gonna/e- going to	Toppin" yersel – suicide
Gote - got	Um - him.
Gouchin" – feeling the effects of a drug	Ur- are.
Gub - mouth	Urnae – are not.
Hame - home	Wey - way

Heid – head Hingin' eye – romantic attraction Hink – think His-sel- himself Hoose – house Hud - had Hus - has Huv – have Iver – ever Jist - just Ken (kenin)- to know, knowing Loat – lot	Whae – who Whin - when Wi – with Widnae – would not Wilnae – will not Wis – was. Wiy (wey) – way Wur - were. Yase/d – use/d Yer- you are. Yi (ye)- you Yi'll- you will Yince – one

Appendix 3: Map of Dumfries and Galloway.



By kind permission of: https://www.dumfries-and-galloway.co.uk/maps/swscotland.htm (2022).

Appendix 4: Drug Classification in Scotland

Scotland (UK) Drug Classifications Under the Misuse of Drugs Act (1971)		
Class A	**Class B**	**Class C**
Heroin, Opium, Methadone	Amphetamines (Speed)	Mild Amphetamines (e.g., Slimming tablets)
Cocaine, Crack	Barbiturates	Tranquilizers (Temazepam, Xanax, Valium)
L.S.D.	Codeine	Anabolic Steroids
Ecstasy	DF118" s (pain killers)	
Any Class B Drug which is injected	Cannabis Resin, Oil, Grass & Skunk Weed	
Processed Magic Mushrooms		
MAXIMUM PENALTIES Under the Misuse of Drugs Act	**MAXIMUM PENALTIES Under the Misuse of Drugs Act**	**MAXIMUM PENALTIES Under the Misuse of Drugs Act**
Possession = 7 years + fine	Possession = 5 years + fine	Possession = Caution, Prison or fine depending on your postcode
Trafficking = Life + fine	Trafficking = 14 years + fine	Trafficking/Cultivation = 14 years + fine

Appendix 5: Participant Information Sheet.

Participant information/script sheet (Version 2 October 17)

TITLE OF PROJECT

An ethnography of what recovery means to rural people who use heroin in their everyday lives in Dumfries and Galloway.

Dear Sir/Madam,

We would like to invite you to take part in a research study. Before you decide it is important that you understand why this research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you would like to take part.

What is the purpose of this study?

Recovery from drug use may have different meanings to different people; the purpose of this study is to explore recovery from the perspective of people who use heroin in a rural environment. It will explore how recovery affects and impacts the everyday lives of people who use heroin, their significant others and the wider community in rural Scotland. Data gathered will be used to understand what specific challenges recovery has for people who use heroin in rural Scotland and what their needs are about recovery. This information is essential for the development and implementation of recovery policies for people who use heroin in rural Scotland. It will help to inform health professionals, criminal justice services and policymakers and may be of use to other people who use heroin and their significant others. The information will also contribute to the researcher's PhD thesis which will be

submitted to The University of Glasgow. This will then be assessed by academics at the university although all participant information will remain anonymous at all times.

Why have I been invited?

You have been invited because you are over 18 years of age, use heroin and live in Dumfries and Galloway.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form, a copy of which you will be given to keep or you may give verbal consent, a consent form will be kept to state that you have given verbal consent. You are free to withdraw at any time without giving a reason. Your participation/nonparticipation will not affect you in any way and any information that you wish removed from the study will be deleted.

What will happen to me if I take part?

This study will involve ethnography meaning you will be interviewed on one or more occasions. The interview/s may take from a few minutes to approximately an hour depending on how long you wish to talk. With your permission, the interview/s may be recorded to allow the researcher to listen to the interview at a later date. The researcher may take written notes either in tandem with the interview or separately. The researcher may also ask your permission to spend time in your company outside the clinical area to gain insight into your everyday life. This, for instance, may involve him visiting your home or local area to understand how you live. He will not interfere with any aspect of your life and be careful not to draw attention to himself whilst in your company and he will leave when requested to do so. All this will take place at a time that suits you.

Will my taking part in this study be kept confidential?

The researcher and their sponsor from The University of Glasgow will have access to your identity to ensure the study is being conducted correctly, no one else will know your identity. Interviews and field

notes will not carry your name, or address or identify you in any way and will be kept securely for up to 10 years within The Glasgow University secure electronic data facility, before being destroyed. Your identity will not be revealed at any time during or following this study and all information will be treated in the strictest confidence. The researcher may keep your details so they can contact you at a later date to clarify the information that you have given. Confidentiality may be breached where there are issues about child safety or where there is an imminent risk of injury or death to you or others. Where there are issues of vulnerability or a psychiatric emergency the researcher may also breach confidentiality by seeking professional assistance from appropriate services.

What are the risks of taking part?

There are no obvious risks for participants involved in this research study.

What are the benefits of taking part?

By agreeing to take part you will help to improve the understanding of how people who use heroin view and are affected by recovery. You will be provided with a platform to give your opinions, advice and experience to people who do not use heroin or engage directly with recovery but write policies or advise people who do. You would provide a unique insight into the challenges faced by people who use heroin in a rural environment; this would contrast with current data which comes from people who used heroin in recovery in urban inner-cities.

What will happen to the results of the study?

The results of this study will be written up and presented as part of the researcher's thesis, which will be submitted for evaluation at The University of Glasgow where he is currently studying for his PhD. On completion of the thesis, information from the study including direct quotes will be used for journal articles that will be developed and sent for publication to relevant journals, these will be read by people interested in this field of research. The researcher also intends to present his findings at a local public forum to which you are welcome, the date and place for this will be identified in the future. Thereafter all materials about data will be kept in secure storage at The University of Glasgow for a maximum of 10 years before being destroyed.

Who has reviewed the study?

N.H.S. Research Ethics Committee (Scotland) and Dumfries and Galloway Research and Development committee.

Contact for further information.

If you require any further information on this research study, please contact me Joe Brown (researcher) directly RM (TBC) or by telephone at 01387 (TBC), email (TBC), or text (TBC). Dr Lucy Pickering (supervisor) tel. xxxxxxxxxxx, email Lucy.Pickering@glasgow.ac.uk. Justin Murray Service Manager for Specialist Drugs and Alcohol Services based at Lochfield Road Primary Care Centre, 12 - 28 Lochfield Road, Dumfries DG2 9BH; Tel- xxxxxxxxxxx

If you have a complaint about any aspect of the research study?

If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance to discuss your concern/s. Should you feel your concerns/s have not been adequately resolved, please use the NHS complaint procedure.

Thank you for taking the time to read this information sheet.

Appendix 6: Consent Form.

University of Glasgow
College of Social Sciences

NHS Dumfries & Galloway

Consent Form

Title of project:

An ethnography of what recovery means to rural people who use heroin in their everyday lives in Dumfries and Galloway.

Aim- to gain an understanding and insight into the everyday lives of people who use heroin, and the meaning recovery has to them, their significant others and the wider communities within rural Scotland.

Name of the researcher.
Joe Brown: PhD student at The University of Glasgow

Please initial the box for each statement and sign at the bottom

I confirm that I enter this research of my own volition and understand that information from this meeting may be used to develop data and themes regarding the title and initial aim as set out above. ☐

I wish to give verbal consent rather than signing the consent form. Where this is the case, the researcher will indicate on the consent form that verbal consent has been given by writing "verbal consent obtained", without identifying the participant. ☐

I permit meetings to be audio-taped, for written notes to be taken and for direct quotes to be used. ☐

I confirm I have read and understand the participant's information (Version 2 October 17) sheet. ☐

I know and understand that I am free to ask questions concerning this study at any time throughout the study. ☐

I understand that my comments and all reports of the findings of this project will be anonymous, that my details may be kept for future contact by the researcher and with data will be held securely by The University of Glasgow, Data Management Service. ☐

I understand confidentiality may be breached should there be issues about child safety, or where there is the immediate and absolute potential of violence or harm to me or another person. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without reason and prejudice and I can ask for any data I provide to be erased. ☐

I understand that my information may be examined by The University of Glasgow

for audit purposes ☐

I agree to take part in the above study. ☐

Name of Participant: ---------- Date: ---------- Signature: ----------

Name of Researcher: ---------- Date: ---------- Signature: ----------

Signature of the researcher to confirm verbal consent from the participant:

_____

Date _____

One copy each

Ongoing consent record -researcher's signature and date

Verbal consent for ongoing participation_____

Date_____

Verbal consent for ongoing participation_____

Date_____

Verbal consent for ongoing participation_____

Date_____

Verbal consent for ongoing participation_____

Date_____

Verbal consent for ongoing participation_____

Date_____

Verbal consent for ongoing participation_____

Date_____

Appendix 7: Flyer

Do you live in Dumfries and Galloway? Do you use Heroin? Would you be interested in helping with research?

Study title: An ethnography of what recovery means to people who use heroin in their everyday lives in Dumfries and Galloway.

You are invited to talk with Joe Brown—PhD student with the University of Glasgow, about:

What meaning does "recovery" have for people who use heroin in rural Scotland?

If you would like to be involved....

Speak with your key worker to set up an appointment.

Contact Joe at the Specialist Drug and Alcohol Service xxxxxxxxxxxx

OR

Email: xxxxxxxxxxxxxxxxxx

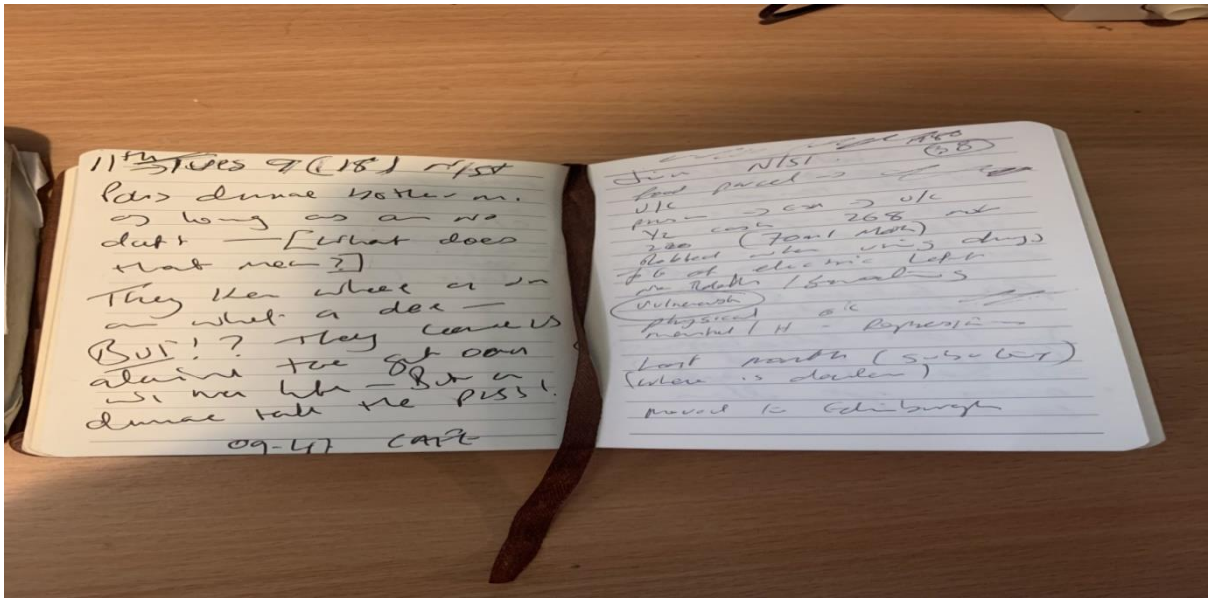
Call/Text: xxxxxxxxxxxxxxx

Home appointments can be arranged at a time to suit you!

University of Glasgow
College of Social Sciences

NHS Dumfries & Galloway

Appendix 8- Field note "jotters" and written example.



Appendix 9: Analytical Process - Coding Example: Themes generated relating to regulated heroin use and identity.

Data extract: (Step 1)	Coded for: (step2)	Generating themes	Refined themes
Deek sits on his living room floor and gets his morning fix ready to inject. He opens a wrap of heroin and sprinkles it carefully onto a well-used metal spoon, adds water and stirs with a needle on the end of his syringe. He adds citric mixing it in carefully as he does. He heats the underneath of the spoon with his Zippo lighter watching it evaporate and thicken with supreme concentration and anticipation. The smell is acrid. He drops a filter on top and draws up every last drop of heroin from the spoon, which he places on a table close by. He pulls back the plunger of the syringe and prepares to administration pulling up one leg of his shorts focusing intently as he searches for a long time trying to locate a vein. He finally goes to inject but stops …looks at me and asks if I want some. I decline. He nods then injects himself. He does not inject the entire heroin only approx. one-third, carefully capping the needle and placing it in his "works box"….before settling back against an armchair, closing his eyes…(Deek; February 2018, his home).	1. Controlled heroin use 2. How heroin is used 3. Signs of chaotic use	1. Regulated heroin use • Sub-themes: - Heroin availability/access - Fear of overdose - Poly-substance use	1. Regulated (considered) heroin use. • Sub-themes: - Heroin available, accessible and affordable. - Heroin use in decline. - Methadone routinely used. - Older demographics
I bump into John outside some shops in town by accident en route to meet someone else. I first met John at the SDAS, and we stop to exchange pleasantries as we do several people pass acknowledging John and one engages in some light-hearted banter for a few minutes before moving on. I ask if they know about him (heroin use) "Of course they dae, everyone knows about everyone's business…you can hide nowt", he is not perturbed….	1. Inclusiveness 2. Anonymity 3. Everyday behaviours	1. Everyday practice • Sub-themes - Being known - Being accepted within their communities - Kinship ties	1. Identity • Sub-themes - Being "normal" - Conventional lives - Not identifying as "addicts" or "junkies"