

**A gendered difference? Female experience of drug and alcohol  
treatment in New Zealand**

By

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The participant information sheet, participant consent form, posters, and human ethics approval are in my maiden name (Flack). I was married during the process of writing this thesis, and all official documentation with the university is now in my married name of Conroy.

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## Abstract

This study examined women's experiences of drug and alcohol treatment in New Zealand, with a focus on Methadone Maintenance Treatment (MMT). The qualitative literature on the treatment experiences of substance-using women is scarce, especially in a New Zealand context, with the majority of literature being quantitative, male-focused, and lacking the female voice. Available literature suggests that substance-using women have unique needs and experiences which must be addressed and acknowledged in treatment for a long-lasting positive change. This thesis aims to explore the experiences of women who have or are attending substance use treatment in New Zealand and their recommendations for improving substance use treatment for women. Areas examined include the experience of stigma, connections and relationships in treatment, and the importance of knowledge. These factors culminate in an exploration of participants' suggestions for improvement. The current study is qualitative, feminist-informed and employed the use of semi-structured interviews with 11 women who have been or are currently in treatment as well as two service providers. The data from these interviews was analysed using Thematic Analysis, finding that women in this study overall had positive experiences. However, there were several areas for improvement suggested by participants including a need for greater access to treatment options, particularly gender-sensitive, holistic approaches. A need for greater knowledge amongst service providers, especially General Practitioners (GPs), on how to treat problematic substance use and the available treatment options was also expressed. Women on MMT had similar, yet varied, experiences compared to those attending other treatments.



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First and foremost, I would like to thank the women who bravely shared their stories and gave their time to talk with me. I hope this thesis represents your stories and experiences accurately and respectfully. Without you, this work would not be possible. I would also like to thank the women who I did not get to speak with. Your interest is appreciated.

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This thesis is dedicated to Evie. Love always.

## Thesis Overview

The objective of this study was to explore women's experiences of drug and alcohol treatment in New Zealand. This thesis focuses on the gendered experiences of women who have used, or do use drugs and alcohol, their experiences of and the impact treatment had on them. It also explores their recommendations for changes that could improve drug and alcohol treatment for women.

A focus was given to the experiences of women on MMT due to the lack of research on the experiences of being on Methadone, particularly for women, and especially in New Zealand.<sup>1</sup>

This thesis privileges the experiences and voices of women who have received or are receiving drug and alcohol treatment in their own words, as well as those of service providers who provide treatment to women. The key research questions guiding this research were:

1. What are the experiences of women who have received or are receiving drug and alcohol treatment in New Zealand?
2. Based on these experiences, what changes would they like to see, and/or what recommendations do they make to improve the provision of drug and alcohol treatment for women?

There is a paucity of literature on the experiences of women in drug and alcohol treatment that privileges their experiences, particularly in the New Zealand context. Therefore, this qualitative, feminist-informed research provides valuable insights into the experiences of women in drug and alcohol treatment.

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<sup>1</sup> The original proposal for this research was to examine women's experiences of Methadone treatment in New Zealand, however, an inability to recruit enough participants resulted in expanding the area of research to all drug and alcohol treatments. Thus, where possible, particular mention and focus has been put on the experiences of those few participants who were receiving Methadone.

It is hoped that this research provides a valuable contribution to treatment literature, particularly in generating awareness of, and appreciation for, the gendered experiences of women in drug and alcohol treatment. It is also hoped that this thesis will provide insights into improvements needed in the provision of drug and alcohol treatment for women in New Zealand.

The introduction provides background information on the experiences of women who use drugs and alcohol and their gender-specific treatment needs. Following this, the literature review in Chapter Two details relevant debates regarding Substance Use Disorders (SUDs), statistics on the use and problematic use of substances, gender differences in substance use, including amount and type of use, gendered barriers to treatment entry, and treatment entry and completion. The review continues by examining stigma and select treatment options and their success (or lack thereof). Chapter Three discusses the methodological approach of this study, detailing the methods used, as well as ethical considerations and practical limitations, with Chapter Four containing a detailed description of each participant. A discussion of the results begins in Chapter Five and examines the theory of stigma, stigma as a substance user and the participant's experiences (or lack thereof) of stigma in treatment and its impact. The importance of connections and relationships is explored in Chapter Six, revisiting literature on the importance of relationships in treatment, as well as detailing the women's own experiences of connections and relationships with friends, family, other women in treatment, and service providers. Chapter Six also explores the theme of knowledge, discussing service providers' knowledge of treating substance use, as well as their and the women's own knowledge of available treatment options. Chapter Seven explores the women's suggestions on what needs to change about the way substance use treatment is provided, discussing their negative experiences and what they would

like to see going forward. Chapter Eight provides concluding remarks to summarise the main findings of this thesis, synthesizing the experiences shared by study participants.

## Chapter One: Introduction

People who use drugs (PWUD) are a hidden and ‘hard to reach’ population (Levy, 2014), with a large amount of distrust for those ‘outsiders,’ who do not use drugs. This distrust extends to medical professionals and other authority figures (Treloar & Rance, 2014). A small amount of research has examined the lived experience of female drug users and treatment services (Gibson, 2016; Williams, 2002; Hutton, 2006; Taylor, 1993; Pini. 2001; Measham, 2002), and which provides valuable insights into the lives of drug users, and how services could be improved. The United Nations Office on Drugs and Crime (UNODC) also released a report in 2016 which explores the effective prevention and treatment of drug use in women and girls and details recommendations for gender-sensitive treatment practices (UNODC, 2016). However, little research exists on the lived experience of female problematic drug users (PDU), women who inject drugs or problematically use alcohol, and those women who seek help for their substance use. This lack of research extends to the New Zealand context, despite the significant harm potential associated with substance use (McFadden Consultancy, 2016). There were an estimated 388,000 illicit substance users in New Zealand in 2012/13, with a combined social and intervention cost to the drug user, their family, and community of \$1.8 billion in 2014<sup>2</sup> (McFadden Consultancy, 2016). It is worth noting that these figures were not separated by gender, and included both dependent and casual substance users, reflecting the historical lack of acknowledgement of the impacts of gender on substance use and its outcomes. These findings also neglected to include the harms of

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<sup>2</sup> This figure includes personal harms to the individual user such as poor health, injury, poor family relationships, imprisonment and loss of income. The figure also includes community harm including the costs from drug-related crime and the impact on friends and family. Finally, the figure also includes the cost of interventions for substance use and substance-related harm (McFadden Consultancy, 2016).

legal substances such as alcohol, tobacco and prescription medication, which, as Nutt, King, Saulsbury, and Blakemore (2007) explain, can result in greater harm than illegal drugs such as heroin. It is estimated that 0.6% of the global adult population (29.5 million people) have a drug use disorder (UNODC, 2017), with a higher rate of increase in the burden of disease from drug use disorders among women than men (UNODC, 2017). This thesis utilises the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) classification of Substance Use Disorder. The DSM-V is a widely-used tool by health professionals to identify mental distress and was therefore, an appropriate source for this research. An in-depth discussion of the criteria is beyond the scope of this research, however, the identifying feature of a SUD is a cluster of cognitive, behavioural and physiological symptoms, whereby an individual continues to use the substance despite significant substance-related complications (American Psychiatric Association, 2013). The symptoms of a SUD fit into four categories: impaired control, social impairment, risky use, and pharmacological criteria (American Psychiatric Association, 2013). More information on these categories can be found in the DSM-V.

Women's experiences of seeking help for their substance use is the focus of this research, an area which continues to be under-researched in New Zealand. These significant research gaps paved the way for the current study, which examines women's experiences of drug and alcohol treatment in a New Zealand context.

Given the broad range of treatment options and components available,<sup>3</sup> the term 'treatment' in this thesis was used to include any and all interventions for substance use from

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<sup>3</sup> There is not scope in this thesis to examine all treatment options. Instead, focus has been given to those treatments which highlight the gendered nature of substance use and treatment experiences. See NIDA (2012) for a more comprehensive discussion on treatment options.

primary healthcare interventions, counselling and drug therapies, to Alcoholics Anonymous (AA) and residential treatment. However, this wide variety of options suggests that clear definitions of what treatment is can be problematic. Stevens (2012) provides the following definition of treatment: “any intervention by medical staff, a therapist or other practitioner that is intended to improve the health of the person with whom this practitioner is in contact” (Stevens, 2012, p. 9). Stevens’ definition emphasises harm reduction<sup>4</sup>, highlighting the health improvements to the individual. However, it also neglects to include peer-led treatments, focusing on practitioners. A lack of academic literature on treatment definitions hinders an informed discussion of this topic. Nonetheless, an examination of the explanations and definitions of treatment on providers’ websites does offer an interesting discussion point. Organisations such as CareNZ (a provider of several drug and alcohol treatment services across New Zealand), ‘Odyssey’ and ‘The Retreat’ offer broad, holistic explanations of their services and what their treatment aims to achieve: changing and improving the lives of their clients (CareNZ, 2017; Odyssey, 2017; The Retreat, 2016). This suggests that, irrespective of the type of treatment provided, ‘treatment’ is focused on personal and relational, significant, long-term, and positive change. The definition of treatment provided in this thesis shares similar aspects to these definitions, viewing treatment as an intervention which provides beneficial improvements to a substance-using individual and the community in a holistic manner. Treatment should focus on personal development, relationships and health factors, not just substance use, therefore, resulting in positive, long-term change. This change is defined by the individual and reduced social costs. It could, therefore, be argued that any service which is not holistic in this respect is not ‘treatment.’ In the context of the current

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<sup>4</sup> Approaches to reduce the harms associated with substance use, such as Needle Exchanges and safe injecting sites (Hunt, 2003).

study, treatments which are not gender-responsive (however that may be defined), could also be considered non-treatments.

This need for gender-responsive treatments is crucial considering women who use substances are seen as doubly deviant, breaking both expected gender norms, and the law (Gibson, 2016). Female substance users face gender-specific stigmatization (Levy, 2014), particularly regarding their ability to care for and raise their children. The rise of the nuclear family<sup>5</sup> in the 19<sup>th</sup> Century saw motherhood become the predominant role of women, with their behaviour expected to be moral and virtuous (Boyd, 2015). Gender-role deviation, such as substance use, was and is seen as abhorrent, justifying social control (Boyd, 2015)<sup>6</sup>. Mothers who use drugs, or have done so in the past are particularly stigmatised (Carter, 2002; Gibson, 2016). These women are often seen as bad mothers, unable to care for their children and provide a safe environment (Malinowska-Sempruch & Rychkova, 2015; Smith, 2006). Substance-using mothers are considered “lethal fetal containers” (Ettore, 2007, p. 31), a danger to their own children, yet a father’s substance use is far less scrutinised, if at all, because a man’s socially accepted and demanded role is not that of the primary caregiver (Ettore, 2007).

The social and cultural construction of drugs<sup>7</sup> and drug users unequally stigmatises and alienates women who use drugs and alcohol, with the ‘War on Drugs’<sup>8</sup> linked to the social control

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<sup>5</sup> A family group consisting of the mother, father and their children (Collins Dictionary, 2017).

<sup>6</sup> This social control will be discussed in later chapters in regards to the criminalisation of pregnant substance users.

<sup>7</sup> A hierarchy of drugs exists from legal, and therefore, more socially acceptable, “good drugs”, such as alcohol and prescription medications, to illegal, “bad drugs”, such as Heroin. This hierarchy is based on a cultural value system and notions of pollution and purity, a hierarchy which impacts both men and women, but disproportionately impacts women (Ettore, 2007).

<sup>8</sup> Efforts to eliminate the sale, distribution and consumption of illegal drugs, which have contributed to mass incarceration and hardship, particularly among communities of colour. There is



of all women, but particularly poor and ethnic minority women (Boyd, 2015). This social control reflects the culturally embedded power imbalances that exist between men and women worldwide (Drug User Peace Initiative, 2014). The regulation, punishment, and criminalisation of substance use is not only gendered, but classed and racialised (Boyd, 2015). Use of illegal drugs, which are socially condemned, results in women, particularly minority women, being criminalised and viewed as abhorrent, and as a danger to their children. Boyd (2015) further explains how drug policy is laden with contradictions, myths, and ideologies surrounding morality, sexuality, reproduction, and mothering, all of which shape drug policy. Women who use illegal substances are portrayed as sexually promiscuous and amoral and subjected to interest in their sexuality that is not extended to men, illustrating one of the many ways women who use substances are regulated in ways that differ from men (Boyd, 2015). This sexualisation was seen in the experiences of women in the early days of AA, with women complaining of being ignored, and meetings in the United States dominated by men (Vourakis, 1989), due to fears over the possibility of sexual relationships forming between male and female members.

This social and cultural construction also contributes to the various barriers women face in accessing and entering treatment, making research on women's treatment experiences difficult, but necessary. Discriminatory views about PWUD are compounded by sex and gender-specific barriers to accessing services (Drug User Peace Initiative, 2014), with women who use drugs (WWUD), their needs and issues significantly under-researched (Gibson, 2016; Rubio, 2013). Anderson (2001) refers to the lack of gender-specific research as the “add women and stir approach”

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widespread agreement that the ‘War on Drugs’ has failed to reduce the harms associated with drug use (Moore and Elkavich, 2008).

(p. 286)<sup>9</sup>. During the 1980s a gender lens developed in drug and alcohol research which encouraged more careful research on substance use, and a recognition of the impacts that social and cultural constructions of masculinity and femininity can have on both individual and group substance use (Anderson, 2001). Yet, the majority of drug research has been conducted on male participants and most often by male researchers (Levy, 2014; Olszewski, Giraudon, Hedrich, & Montanari, 2009). Furthermore, the majority of drug policy and harm reduction approaches are designed by males, with male consumers in mind (Levy, 2014), subsequently neglecting the unique needs of female consumers (McGauley, Scorthorne, & McCamley-Finney, 2002). It appears that women only become a focus when they contravene the norm of the ‘good woman’, the moral, submissive character. Research suggests that WWUD see their drug use differently, experience different relationships, view their treatment needs differently, and experience added stressors and barriers to treatment that men often do not, such as childcare and transport concerns (Williams, 2002). The research that has been conducted about WWUD demonstrates the need for gender-sensitive programmes and treatment approaches to effectively implement harm reduction policies (McGauley et al., 2002).

This study examines the experiences of women in New Zealand who are currently receiving treatment<sup>10</sup> for drug and alcohol issues or have done so in the past. A focus has been given to MMT due to the lack of research in this area. Chapter Two will discuss relevant background literature for the current study.

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<sup>9</sup> By this, Anderson (2001) is referring to the lack of inclusion of women in substance use research. When women were included, research methods and interests continued to be male-focused and dominated.

<sup>10</sup> Treatment refers to the various interventions and programmes attended by the women in this study. Refer to the previous discussion on the author’s conceptualisation of gender-sensitive treatment.

## **Chapter Two: Literature Review**

This chapter explores the necessary background information for this research. Areas of research discussed focus on gender differences and include: alcohol use and misuse, prescription drug misuse, the impact of abuse and trauma on substance use, treatment seeking, entry, completion and outcomes, stigma and substance use, and treatment options as a gendered experience. These main areas of research were canvassed as they coincided with the key aspects of research for this thesis, and the experiences of its participants.

SUDs are generally more common among men than women (Hecksher & Hesse, 2009), with women statistically less likely to drink alcohol or use illicit drugs (Green, 2006). However, women who do use substances, particularly problematic users, experience gender-specific stigmatization, have unique and different treatment needs, and have had their voices neglected (Carter, 2002; Gibson, 2016; Levy, 2014; Williams, 2002). Research suggests that some of the causes and consequences of substance misuse are different for women than for men, necessitating gender-specific treatment approaches and adaptations (Beckman, 1994). In the United States, research indicates that women's use of alcohol and drugs has been increasing, necessitating new studies to explore this issue (Greenfield, 2002). Some New Zealand studies also indicate an increase in women's drinking and illicit drug use, suggesting a convergence of men and women's drinking patterns, although, others do not support this convergence (Alcohol Health Watch and Women's Health Action, 2013; Ministry of Health, 2017; Wilkins, Casswell, Bhatta, & Pledger, 2002). Drinking patterns are often impacted by ethnic, socio-economic and gender identity differences (Alcohol Health Watch and Women's Health Action, 2013), highlighting the multitude of factors which determine substance use, and, therefore, impact treatment. As with research into drug misuse and dependence, studies of problematic alcohol use have primarily consisted of male

participants, because they were an easier sample to obtain. Studies that have examined both male and female alcohol use have usually underrepresented women (Greenfield, 2002). This underrepresentation of women reflects the historical belief that alcoholism and alcohol misuse is a male problem (Buccelli, Della Casa, Paternoster, Niola, & Pieri, 2016). It was not believed that women could have problems with alcohol and other drugs because they were the moral and rational members of society (Cohen, 2000), a reflection of the social construction of drugs and drug users discussed in Chapter One, and the concept of ‘good’ and ‘bad’ women. This social construction and the resulting stigma (discussed in more detail throughout this thesis) results in women being less likely to seek treatment for their alcohol and drug misuse, particularly in specialist treatment facilities (Greenfield, 2002). When women do seek treatment, it is often through primary care doctors, and social or mental health services (Greenfield, 2002). Women with problematic substance use also face several barriers to treatment entry, including both internal barriers, such as a denial of a problem with substance misuse, and external barriers such as childcare, transport, and stigma (Cooksey, 2006). The predominant focus on abstinence-based treatment models, particularly in the United States, may also act as a barrier to women’s treatment entry (Witkiewitz, 2013). The majority of public or state-funded treatment options in the United States are based on abstinence models, with abstinence as a measure of success (Subbaraman & Witbrodt, 2014). A significant proportion of funding for these treatments and research into problematic substance use is from the National Institute on Drug Abuse (NIDA) which sees abstinence as the only option for problematic substance use, promoting the Disease Model<sup>11</sup> (Hall, Carter, & Forlini, 2015; Valkov,

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<sup>11</sup> The Disease Model theorises that problematic substance use is a chronic, relapsing, incurable brain disease, with a focus on neurobiology and neurochemicals, the individual losing control over their substance taking (Courtwright, 2010; Hall et al., 2015). Problematic substance users are not held

2015). Courtwright (2010) refers to this as the “NIDA Paradigm” (p. 137). If programmes wish to keep receiving funding, they must continue to subscribe to an abstinence-based model. However, abstinence is not the goal of every problematic substance user and may act as a deterrent to treatment entry (Redko, Rapp, & Carlson, 2007). Much of the support for the Disease Model comes from studies on animals, which are limited in their generalisability to humans (Hall et al., 2015). Human studies focus on a small sample of problematic substance users and fail to explore the fact that most people exposed to an addictive substance do not become problematic users (Willbanks, 1989). Critics of the Disease Model also highlight how it fails to account for the significant number of problematic substance users who ‘recover’ without treatment (natural recovery; Conde, Lichtenberger, Santáneglo, & Cremonte, 2016; Hall et al., 2015). Personal agency and the impact of social, cultural and economic factors on substance use are also ignored, significantly limiting the provision of crucial aspects of treatment such as vocational and life skills (Ngo, 2008; Valkov, 2015). Some critics also view the Disease Model as positioning substance users as victims, removing all personal responsibility and creating a sense of learned helplessness which will reduce their likelihood of entering treatment<sup>12</sup> (Ngo, 2008; White, 2001; Willbanks, 1989). Whilst the Disease Model may go some way to counteracting the previous view of problematic substance use as a moral problem of the weak-willed (Hammer et al., 2013), Hall et al. (2015) argue that it does not bring the developments in treatment promised by NIDA. This perceived lack of treatment development is troubling given the statistics available on problematic

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accountable for their substance use under this model (Ngo, 2008). There are significant criticisms of this approach including Satel and Lillienfeld (2014) and Hart (2017).

<sup>12</sup> This helplessness and victimhood mirrors feelings often felt by abuse victims, with many female problematic substance users experiencing abuse in their lifetime. This suggests that the Disease Model is not gender-responsive, having a negative impact on treatment entry for women.

substance use and treatment seeking, along with the necessity for gender-sensitive treatments, which will be established throughout this thesis.

### **Alcohol Use and Misuse**

Alcohol misuse and dependence is a significant and growing concern globally. A 2015 survey found that 15.1 million people in the United States had an Alcohol Use Disorder (AUD).<sup>13</sup> This number included 9.8 million men and 5.3 million women (National Institute on Alcohol Abuse and Alcoholism, 2017). Approximately 1.3 million adults received treatment at a specialist treatment facility (National Institute on Alcohol Abuse and Alcoholism, 2017). This survey also estimated that 623,000 adolescents aged 12-17 had an AUD, with around 37,000 receiving treatment through a specialised facility (National Institute on Alcohol Abuse and Alcoholism, 2017). These statistics reflect the continued lack of treatment seeking and completion among those with AUDs (Kuramoto, Martins, Ko, & Chilcoat, 2011), a possible reflection of the normalisation and acceptance of alcohol use, including heavy use, in society (VicHealth, 2013), with alcohol constructed more favourably than demonised illegal drugs. The burden of alcohol-related issues exists worldwide, with 3.3 million deaths related to alcohol consumption in 2012 and alcohol misuse being the fifth leading cause of premature death and disability globally. It is the first leading cause of death and disability for those aged 15-49 (National Institute on Alcohol Abuse and Alcoholism, 2017). The misuse of alcohol, tobacco, and illicit drugs costs the United States approximately \$700 billion annually in costs related to crime, lost productivity and healthcare

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<sup>13</sup> AUD has subsumed the previous categories of alcohol abuse and dependence listed in the Fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), with the characteristics of AUD, and the wider category of Substance Use Disorder listed in the fifth edition of the DSM (DSM-V).

(NIDA, 2015a). The estimated social and intervention costs in New Zealand totaled \$1.8 billion in 2014/15 (Ministry of Health, 2016).

With these figures come a significant concern surrounding alcohol misuse and dependence in adolescence. A 2007 New Zealand mental health survey found that 17% of those interviewed (aged 16-24) met DSM-IV criteria for alcohol ‘abuse,’ and 6.5% met criteria for alcohol dependence (Fergusson & Boden, 2011). Furthermore, the percentage of adults with hazardous drinking patterns appears to be increasing (Ministry of Health, 2016). In 2012/2013, alcohol was the most commonly used recreational drug in New Zealand, with heavy and binge drinking behaviours most common in younger adults (Ministry of Health, 2015). Males were also more likely to drink at a higher frequency, with young adults, males and Māori<sup>14</sup> drinkers reporting drinking to intoxication more frequently than other groups surveyed (Ministry of Health, 2015). Some data suggest that women’s drinking patterns are converging on men’s and that young women are drinking a greater volume of alcohol than previously (Alcohol Health Watch & Women’s Health Action, 2013).<sup>15</sup> In 2004, the 12-month prevalence for AUD’s<sup>16</sup> in New Zealand was 2.20% for females and 3.50% for males aged over fifteen (World Health Organization, 2010). Data also suggests that the number of young women (aged 16-17) drinking has decreased, but those who are drinking, are doing so in a harmful way (Alcohol Health Watch & Women’s Health Action, 2013).

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<sup>14</sup> Māori are the indigenous population of New Zealand.

<sup>15</sup> Alcohol use in older women is also a concern. Blow and Barry (2002) highlight how older women are at risk of alcohol issues because they are more likely than men to outlive their partners, and may also face other losses that contribute to loneliness and depression. The physiological complications of alcohol use for women also increase as they age (Blow & Barry, 2002), necessitating the development of successful treatment options for older women.

<sup>16</sup> As per the DSM-V definition.

Examining the above patterns and statistics, along with those on drug misuse in Chapter One allows for a better understanding of the gendered nature of substance use and misuse, and the need for gender-sensitive treatment options. This is further evidenced in prescription drug use and misuse which is discussed next.

### **Prescription Drugs**

Prescription drug misuse is a growing public health concern, particularly in New Zealand. With New Zealand's geographical isolation and a smaller economy, the importation and smuggling of illicit drugs in bulk is difficult (Ministerial Committee on Drug Policy, 2007). Prescription drug misuse has been a long-term concern in New Zealand, although, this has often been overshadowed by media coverage of the growing and manufacture of Cannabis and Methamphetamine (Robinson, Judson, Loan, Bevin, & O'Connor, 2011). Robinson et al. (2011) examined the rate of prescription drug misuse in new patients at three drug and alcohol treatment services in New Zealand. Of the 37 participants (26 males), 10 reported their sole drug of choice being intravenous (IV) Morphine. Twelve reported Methadone and 11 used a mixture of Opioids (mostly Methadone and Morphine), but also prescription pain medications such as Tramadol and Oxycodone. Seventeen also reported using hypnotosedatives,<sup>17</sup> although, their use was not high (Robinson et al., 2011). The lack of women in Robinson et al.'s (2011) sample is likely a reflection of their lack of presentation to specialist treatment services (Greenfield, 2002), hampering research on gendered patterns of prescription drug taking. Nonetheless, some studies suggest that women are more likely to use prescription drugs as their drug of choice (Ford, Reckdenwald, & Marquardt, 2014; Green Serrano, Licari, Budman, & Butler, 2009). This may be in part due to prescription drugs being prescribed

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<sup>17</sup> Drugs such as Benzodiazepine's, often prescribed from sleep-related disorders (Somers et al., 2011).



to women at a higher rate than men (Green et al., 2009). The 2008 National Survey on Drug Use and Health in the United States reported that approximately 4.7 million people aged 12 and older had used prescription drugs for non-medical purposes in the last month, and 1.7 million people met DSM-IV criteria for dependence or abuse<sup>18</sup> (Back, Lawson, Singleton, & Brady, 2011). Between 1999 and 2008, there was a 400% increase in the number of people admitted for treatment for prescription Opioid use in the United States, highlighting a significant impact on both drug users and the public health system (Riggs, 2008; Substance Abuse and Mental Health Services Administration, 2010). In the United States, Cannabis is the only illicit drug more widely used than prescription drugs (Kuehn, 2007). Prescription drugs continue to be more utilised and available in medical care, some argue due to physicians receiving financial incentives, gifts and professional development opportunities from pharmaceutical companies for prescribing their drugs (Goldacre, 2014), which has seen a significant increase in their non-medical use and misuse (Riggs, 2008). Riggs (2008) believes there needs to be more education about and awareness by medical staff of their prescribing practices and prescription medication misuse. However, research into the non-medical use of prescription medications is complicated by a lack of an agreed definition of non-medical use and the different ways in which a prescription drug can be used non-medically (Arria & Wish, 2006). Prescription Opioid's such as Morphine and Codeine are some of the most widely misused prescription drugs (Compton & Volkow, 2006). Opioid misuse will be discussed in more detail in the following section.

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<sup>18</sup> The diagnosis of 'abuse' is no longer used in the DSM-V, however, to accurately present these findings at the time of their publication, 'abuse' will be used when discussing DSM-IV diagnoses.

## **Opioid Misuse**

Opioid misuse is a global issue, with considerable social and health repercussions (McFadden Consultancy, 2016; New Zealand Drug Foundation, 2016). These include but are not limited to: disease and infection from injecting, organ damage, overdose, criminality, loss of occupation and family, as well as financial costs (Hunt, 2003). The highly addictive nature of Opioids results in a significant dependence potential (New Zealand Drug Foundation, 2016), although, psychological, social and cultural factors also contribute to drug effects and outcomes (Hartogsohn, 2017; Zinberg, 1984), not only substance physiology.

Drug overdose is the main contributor to accidental death in the United States, with Opioid misuse driving the epidemic. In the United States in 2014 there were 18,893 overdoses involving prescription pain medications, and 10,574 overdoses related to Heroin (American Society of Addiction Medicine, 2016). As these figures demonstrate, licit, prescription drug misuse is a serious concern. This is further reflected in the number of individuals over the age of 12 who had a SUD involving prescription drugs (1.9 million) compared to 586,000 involving Heroin in the United States in 2014 (American Society of Addiction Medicine, 2016). As discussed above, there is a gender difference in prescription drug use, with women more likely to have chronic pain, be prescribed pain medications, receive higher doses and take them for a longer period than men. Women may, therefore, become dependent on prescription pain relievers faster than men (American Society of Addiction Medicine, 2016).

## **Opioid Use and Misuse in New Zealand**

In New Zealand, there are approximately 37 recorded Opioid overdose deaths per year, however, this is likely to be a significant underestimate (New Zealand Drug Foundation, 2015). New Zealand's figures may be small compared to countries such as the United States, but

prescriptions for Opiate pain relievers continue to rise, drastically increasing their harm potential (New Zealand Drug Foundation 2015).<sup>19</sup> The Ministry of Health's 2007-2008 New Zealand Alcohol and Drug Use Survey reported that 3.6% of adults aged 16-64 had used an Opiate recreationally during their lifetime, including prescription drugs (Ministry of Health, 2010). New Zealand has had a limited supply of Heroin since the undoing of the Mr. Asia drug ring in the 1970s, which has created the ideal environment for the black market selling of prescription drugs (Robinson et al., 2011). Morphine and Methadone appear to be the most popular street prescription drugs used (Robinson et al., 2011), however, drug testing organization Know Your Stuff NZ<sup>20</sup> confirmed that Fentanyl had reached New Zealand in the summer of 2017-2018, with serious concerns for its overdose and harm potential. With prescriptions for Opiate pain relievers continuing to increase, there is a growing need for improved harm reduction initiatives, not only in New Zealand, but globally. The gender differences observed in prescription drug use also further highlight the need for gender-sensitive treatment, with additional gender differences in drug use and misuse discussed below.

### **Gender Differences in Substance Use and Misuse**

As discussed earlier, a gender difference exists in the likelihood of initiating substance use, substance misuse and the type of substance used (United Nations Office on Drugs and Crime-UNODC, 2004). For example, women are overall less likely to use illicit substances such as

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<sup>19</sup> The smaller rate of Opioid-related deaths in New Zealand can be attributed to several factors such as a lower rate of Opiate use, restricted supply because of geographical location, pharmaceutical purity, as most of the Opiate supply is prescription medications, as well as limitations in data collection (New Zealand Drug Foundation, 2015).

<sup>20</sup> Know Your Stuff NZ is a not-for-profit, volunteer-led organization, working with the New Zealand Drug Foundation to provide drug-related harm reduction services to events around New Zealand. This includes drug checking. <https://knowyourstuff.nz>

Opioids and Cocaine, but are more likely than men to consume licit pharmaceutical substances (most often prescription pain medication; UNODC, 2004). Men are two to three times more likely to develop drug misuse or dependence disorders than women, and four times more likely to have an AUD (Buccelli et al., 2016). These differences are related to biological responses to the drug, the progression of the dependence, and co-morbid psychiatric conditions (Buccelli et al., 2016), along with social and cultural factors. Reactions to substances and the outcomes of these reactions are often dependent on the environment surrounding the user, not just the substance and the individual. Alexander, Coombs, and Hadaway (1978) demonstrated the positive effects of improved living conditions and social interaction in rats who self-administered Morphine. While this research is limited in its generalisability to humans, it does indicate the importance of negative social and economic conditions on substance use. Research also suggests that women are more vulnerable to the effects of alcohol and some drugs (UNODC, 2004). Compared to men, women become intoxicated from a lesser amount of alcohol, metabolize it differently, develop medical complications faster, and are more likely to die from alcohol-related incidents (Cooksey, 2002; Greenfield, 2002). However, older women have been found to have a higher blood alcohol level than younger women after drinking, indicating that age is also a significant variable in the effects of alcohol consumption (UNODC, 2004). Studies suggest women begin drinking later in life than men, but enter treatment at about the same age, indicating a faster development of alcohol-related issues, a phenomenon known as Telescoping (Buccelli et al., 2016). These findings indicate that women's problematic use of alcohol may be more acute than men's. Despite this, the focus remains on men, rather than women in research and treatment settings. It is also important to note the existence of individual differences: not all women will experience the same effects, with social, cultural, environmental, psychological and physical differences all impacting a woman's

experience of, and reaction to, substance use (McElrath & McEvoy, 2002). The drug, set and setting<sup>21</sup> also plays a significant role in an individual's propensity for substance use, their experiences, and outcomes of substance use (Weil, 1972, as cited in Shewan, Dalgarno, & Reith, 2000; Zinberg, 1984). Measham (2002) also argues that the gendering of both set and setting are central to the drug-taking experience for women.

As discussed previously, despite the potential complications of problematic substance use, women are less likely to seek help from specialist drug and alcohol treatment services. They are more likely to seek help via primary care settings, mental health and social services (Greenfield, 2002). This may reflect female-specific barriers faced in accessing and completing treatment (Brown, 2009; Greenfield, 2002). Such barriers include, but are not limited to: a lack of financial stability and ability to afford treatment, lack of support from family and friends, child care responsibilities and lack of access to childcare facilities, as well as fear of losing their child or children to the state, a lack of transport, heightened perceptions of stigma surrounding women's alcohol and drug use, and a history of physical and sexual abuse, which may result in a reluctance to attend mixed-gender treatment options (Brown, 2009; Greenfield, 2002; Levy, 2014; Powis, Gossop, Bury, Payne, & Griffiths, 2000). Children are a strong motivator for women entering treatment but fears about the safety and care of their children, while they are in treatment, is a primary reason for poor treatment attendance (Brown, 2009), with many of these barriers being cross-cultural (Otiashvili et al., 2013). Substance-using mothers also face unique barriers to treatment with regards to the perceived stigma of being a 'bad mother,' and the criminalisation of

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<sup>21</sup> 'Drug' is the physical substance whilst 'set' is the person's expectation of what the drug will do. 'Setting' refers to the physical and social environment in which the drug is taken (Shewan et al., 2000).

drug use whilst pregnant in some countries (Ferguson & Kaplan, 1994; Otiashvili et al., 2013). The United States 'war on drugs' historically prosecuted mothers using Crack Cocaine whilst pregnant (Ferguson & Kaplan, 1994; Otiashvili et al., 2013), which will be discussed further shortly. Experiences of abuse may also act as a barrier to treatment seeking for many substance-using women, discussed in more detail in the following section.

### **Impact of Sexual and Physical Abuse and Trauma**

Women are more likely to have been victims of physical and sexual abuse at some point in their life (UNODC, 2004), which can have a significant impact on their substance use and treatment success (UNODC, 2004), demonstrating the impact of social and cultural factors on substance use. Intimate Partner Violence and relationship stressors are a trigger for relapse in many women and may result in continued substance use or drop out from treatment services (El-Bassel et al., 2004), further exemplifying the impact of social and cultural factors on substance use. Problematic substance use is more than brain wiring, rather, it is a complex combination of individual, social, cultural, economic and political factors (Buchanan, 2006; Buchanan, 2011; Spooner & Hetherington, 2004; Sudhinaset, Wigglesworth, & Takeuchi, 2016). Abuse can leave women vulnerable to exploitation by male partners, who are often substance users themselves (Olszewski et al., 2009), and also contributes to the low levels of self-esteem experienced by many substance-misusing women (Cowan et al., 2003). Childhood abuse also often leaves these women vulnerable to developing a substance-related problem (Olszewski et al., 2009). Experiences of abuse can result in the development of Post-Traumatic Stress Disorder (PTSD) and other forms of psychological distress (UNODC, 2004). Rates of PTSD in cohorts of women in alcohol and drug treatment range from 30 to 59% (UNODC, 2004). Women with SUDs also report higher rates of psychiatric symptoms or diagnosed psychiatric disorders compared to men, most often Depression,

Anxiety, Borderline Personality and Eating Disorders (UNODC, 2004). These psychiatric disorders more often precede substance use in women than in men, indicating that women often use substances to cope with these conditions (Back et al., 2011; UNODC, 2004). These preceding psychiatric conditions indicate that the root causes of substance use are social and cultural factors, rather than brain wiring, as proposed by the Disease Model. Psychiatric conditions may also influence an individual's treatment seeking for their substance use.

### **Treatment Seeking**

Many in need of, or who are seeking help for their alcohol and drug use do not necessarily meet the criteria for a SUD (Foulds, Wells, Lacey, Adamson, & Mulder, 2012), which has repercussions for their treatment seeking and success (Foulds et al., 2012). These individuals are still at risk of serious harm but are less likely to seek help (Foulds et al., 2012). This lack of treatment seeking could be the result of not perceiving their substance use as problematic, believing they can cope with the issue themselves or thinking they will recover spontaneously (Foulds et al., 2012). Those with hazardous or harmful substance use do, however, attend primary care settings for other health-related concerns (Foulds et al., 2012), with primary care settings playing a crucial role in identifying and treating SUDs (Millette & Cort, 2013). Physicians can be a powerful influence in convincing a patient to accept treatment (Weaver, Jarvis, & Schnoll, 1999). Primary care settings also offer the opportunity for low-level treatment options for less severe patients (Weaver et al., 1999), although, as will be discussed, primary care settings can also be a source of stigma. Foulds et al. (2012) found harmful and hazardous drinking present in 17.7% of their New Zealand sample, with these behaviours more common in men than women, and in younger age groups. Only 3% of those who visited their primary care doctor in the last 12 months mentioned being talked to about alcohol use (Foulds et al., 2012), highlighting the lack of

recognition and discussion of alcohol issues in a primary care setting. Millette and Cort (2013) discuss how this lack of recognition and discussion may be a factor in primary care physicians being reluctant to and feeling ill-equipped to discuss substance use problems with their patients, indicating a need for more education and training around substance use problems. This lack of discussion and acknowledgment is reflected in the experiences of women in the current study, many of whom struggled to access treatment due to a lack of knowledge and awareness of treatment options. Doctors also failed to be a source of information on treatment options, a factor discussed further in Chapter Six.

### **Gender Differences in Treatment Entry, Completion and Outcomes**

Evidence for gender differences in treatment entry, completion and outcomes are mixed. A study of Heroin and Cocaine users in the United Kingdom found that male Cocaine users were more likely to have contacted a treatment provider than women, but no gender differences were found for Heroin users (UNODC, 2004). In the United States, two studies found that women who did contact treatment providers were less likely to enter treatment than men, but other studies have found no gender difference (UNODC, 2004). Overall, women seeking treatment are more likely to be younger, with fewer resources with regards to education, employment and income (UNODC, 2004). They are also more likely than men to be the sole carer for a child or children and to have a partner who also uses or misuses substances (UNODC, 2004). Other studies suggest that gender either has no impact on treatment initiation or, if it does have an effect, women are more likely to initiate treatment than men (Green, 2006). Women also appear at least as likely as men to engage in and complete treatment, with treatment outcomes for women being as good, if not better than men's (Green, 2006). Inconsistent findings of gender differences in treatment completion and outcomes also indicate that individual circumstances and motivations play a role in treatment, a



factor evidenced in the current study. Whilst many women experience barriers to treatment, not all women will experience the same barriers or experience barriers at all. However, one barrier experienced by many women who use substances is stigma.

### **Stigma and Substance Use**

Erving Goffman (1963) defined stigma as recognising difference in an individual or group based on a defining mark or characteristic and devaluing the individual because of this difference. Goffman (1963) describes how stigmatized individuals are seen or perceived as flawed and denied the privilege of full humanity. These individuals are no longer fully-fledged members of society (Trevor, 2011). Link and Phelan (2001) see stigma as occurring when several societal factors come together, with stigma the sum of these components. The first component occurs when individuals identify and label differences. Dominant cultural beliefs then label individuals with these undesirable characteristics, attracting negative stereotypes (Link & Phelan, 2001; Wilson, 2014). These labelled persons are thirdly assigned to ‘us’ and ‘them’ categories, creating a degree of separation between the ‘normal’ and the stigmatised. This labelling leads to discrimination and a loss of social status resulting in differential outcomes for the stigmatised compared to the non-stigmatised (Link & Phelan, 2001; Wilson, 2014). Lastly, stigma occurs when the stigmatised individual lacks access to social, political, and economic power. The non-stigmatised have privileged access to these forms of power, which enable them to identify and label difference, construct stereotypes, create the ‘us’ and ‘them’ distinction and impose rejection, exclusion, and discrimination upon the othered person or group (Link & Phelan, 2001; Wilson, 2014). Stigma also manifests itself as self-stigma, social-stigma and structural-stigma (Gibson, 2016; Livingston, Milne, Fang & Amari, 2012, as cited in Wilson, 2014). Self-stigma is the internalisation of others’ negative perceptions and opinions of one’s own ‘group’, whereas social-stigma is when large

social groups endorse and act upon stereotypical perceptions of a particular group (Ahern, Stuber, & Galea, 2007; Livingston et al., 2012, as cited in Wilson, 2014). Finally, structural-stigma refers to the political procedures and the practices of institutions which limit the rights and opportunities of stigmatised groups (Livingston et al., 2012, as cited in Wilson, 2014). Problematic substance users experience all three forms of stigma, impacting their lives in many ways including job and healthcare discrimination, poorer health outcomes, lack of treatment seeking or early drop-out from treatment, mental health problems, and social isolation (Earnshaw, Smith & Copenhaver, 2013). Substance users may also experience stigma based among others, on their ethnicity, gender, social status, and income level (Goffman, 1963). Buchanan (2011) argues that the stigma, alienation, and discrimination experienced by problematic substance users is a far more powerful tool for keeping an individual in their patterns of problematic substance use than the substance itself. This is particularly the case for illicit drug users, who Buchanan (2011) contends are subject to institutionalised, structured discrimination, limiting their access to social capital. As will be discussed below, stigma can be a significant aspect of a substance user's life, and their treatment seeking. The women in the current study were no exception, experiencing stigma from strangers, friends, family, health professionals and themselves. These women's experiences of stigma will be discussed further in Chapter Five.

The stigmatization of PWUD has a long history, with medical practitioners in the 1920s viewing PWUD as defective individuals, trying to compensate for their inferiorities. PWUD were seen as one of the most deviant groups (Trevor, 2011). Crisp, Gelder, Rix, Meltzer, and Rowlands (2000) found that, in a survey of 1737 people aged 16 and over, Schizophrenia, drug addiction, and alcoholism elicited the most negative responses. Seventy-percent of their sample thought that those with the above conditions were dangerous to others, and 80% rated them as unpredictable

(Crisp et al., 2000). Those with problematic alcohol and drug use were rated as being to blame for their predicament, and as having the ability to help themselves (Crisp et al., 2000). Respondents in Link, Phelan, Bresnahan, Stueve, and Pescosolido's (1999) study also believed that problematic alcohol use was caused by an individual's own bad character. The stigma surrounding alcohol misuse and dependence is also a concern, particularly for women. SUDs are perceived as part of the cohort of externalising behaviours,<sup>22</sup> which are typically displayed by men (Hecksher & Hesse, 2009). It is believed and expected that women do not display these externalising behaviours, and so, women who do can experience significant stigmatisation, particularly self-stigma (Hecksher & Hesse, 2009). Substance-using women often experience views held by society (and themselves) of having 'fallen from grace' and being incapable of living up to the image of a responsible individual and mother (Raeside, 2003). This can result in a significant amount of shame and guilt surrounding their substance use and reduce their likelihood of seeking help for fear of further stigmatization (Hecksher & Hesse, 2009).

For women, stigma is particularly prevalent in regard to the double stigma they face as both women and substance users (Cohen, 2000). This double deviancy and double stigma have been explained above with regards to WUUD. Society also tends to accept male drunkenness and even promote it through certain activities. However, drunkenness has never been accepted in women and has been linked to promiscuity, immorality and unfeminine behaviours (Cohen, 2000; Boyd, 2015; George, Gournic, & McAfee, 1988; Blume, 1991; Chapman, 1997). Stigma is a significant barrier to positive and successful treatment outcomes, resulting in a lack of treatment

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<sup>22</sup> Externalising behaviours are negative behaviours directed outwards (Jacob et al., 2014). The act of using substances to cope with undesirable mental states and emotions is directing these emotions into the external environment via the physical act of using substances.

uptake and retention (Trevor, 2011). Leshner (1997) highlights some of the negative perceptions of individuals with problematic drug use. These include viewing PDU's as victims of their own situation, and individuals who are bad or weak, unable to exhibit self-control, continuing to indulge in instant gratifications (Leshner, 1997). Whilst stigma is pervasive in the lives of substance users, it could be argued that the type and extent of stigmatisation is dependent on social and cultural situations and is socially constructed. The extent of stigmatisation experienced may also depend on the substance consumed, reflecting the socially constructed hierarchy of drugs discussed in the introduction. Bancroft (2009) discusses how problematic alcohol users often have a higher social status than PDU's in the community. This perceived greater social status is the outcome of multiple factors, such as the criminalisation of illegal drug use. Conversely, Methadone clients have a significantly lower social status.

Those on Methadone are frequently perceived in a negative light by both medical practitioners and the public. Perceptions of Methadone clients include seeing them as 'addicts', impulsive, weak-willed, unemployable, untrustworthy, and dysfunctional (Zweben & Sorensen, 1988, as cited in Trevor, 2011). The stigma and discrimination experienced by substance users can have serious consequences for their physical and mental health. Not only are PWUD and alcohol misusers less likely to access and remain in healthcare and treatment because of stigmatisation, they are also more likely to experience mental health concerns such as Depression and Anxiety (Ahern, Stuber, & Galea, 2007).

### **Stigma from Health Professionals**

Healthcare professionals and pharmacists play a central role in the stigmatisation of problematic substance users. They are often documented as part of the problem and are also a main source of interaction with substance users (Lloyd, 2010). The beliefs and attitudes of

clinicians and treatment staff can have a significant impact on treatment experiences and outcomes. It is suggested that those who work with female substance users should be empathetic, warm and understanding (Brown, 2009), with surveys of staff attitudes producing mixed results. Cowan et al. (2003) in a study of New Zealand treatment staff found that most staff supported the need for women to receive different treatment than men, however, one-quarter of those surveyed did not support this view. A 2006 survey of staff working in five treatment agencies in Chicago found that staff described women as being both victims, and as being manipulative. Women receiving treatment were associated with more negative characteristics by staff than men (Brown, 2009), reflecting the double deviancy stigmatisation experienced by many women who use substances.<sup>23</sup> Raeside (2003) examined the attitudes and knowledge of midwives working with drug-exposed mothers and infants, and concluded that the attitudes of these midwives were negative and judgemental towards drug affected mothers and that they lacked knowledge about drug-using women and their lifestyles. Raeside (2003) also found that more experienced midwives had more negative attitudes than those new to working with neonates. She concluded that there needed to be more education for midwives on substance misuse and how it impacts neonates and mothers (Raeside, 2003). The treatment experiences of women in the current study also reflect this lack of education and knowledge held by health professionals in treating substance misuse in women.

As discussed above, those receiving Methadone face stigmatisation from health professionals, family, friends, strangers and themselves. The next section will explore the literature on the stigmatisation of those on Methadone, an important discussion in this thesis' focus on MMT.

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<sup>23</sup> Women who use substances face additional stigmatisation due to 'breaking' perceived gender norms of wife, mother and moral, 'good' women, alongside the law (Gibson, 2016).

## Stigma and MMT

MMT is greatly misunderstood, receiving negative coverage across various media platforms (Joseph, 1995). Media coverage often emphasises the sensational, portraying Methadone clients as non-compliant drug users who loiter in the streets. They have been portrayed as dysfunctional, homeless individuals who are unemployed, and disease-ridden (Joseph, 1995). The term ‘Methadonian’ is a clear reflection of the stigma and misunderstanding surrounding MMT. This expression denotes an ‘alien’ who uses Methadone, the persons’ status as a member of the human race removed (Joseph, 1995; Montagne, 2002). The origins of this term are unknown; however, it was first thought to appear on the streets in the 1970s, later picked up by the media as a useful tagline (Joseph, 1995). Some believe it may have originated from stable, employed Methadone clients to describe counterparts they viewed as dysfunctional (Joseph, 1995), reflecting the hierarchy and stigma that exists, even within the community of PWUD, as well as Hutton, Griffin, Lyons, Niland and McCreanor’s (2016) *Positioned Othering*.<sup>24</sup> As with other PWUD, those on Methadone experience stigma, prejudice, and discrimination from multiple sources, including family, friends, employers co-workers and healthcare professionals (Earnshaw et al., 2013). Methadone clients often feel the need to conceal their treatment from those closest to them to avoid stigmatization (Joseph, 1995), a factor discussed by participants in the current study. This contradicts the expectations often communicated by both clients and clinicians of exhibiting openness and truth-telling in their treatment. Those on Methadone believed their family saw them as untrustworthy and likely to steal from them (Joseph, 1995). One female Methadone

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<sup>24</sup> Positioned Othering refers to individuals attempts to distance themselves from the perceived negative and stigmatised drinking behaviours of their peers, despite engaging in the same kinds of drinking practices. Despite drinking in these same ways themselves, other women who engage in ‘socially inappropriate’ drinking behaviours are ‘othered’ (Hutton et al., 2016).

client in Earnshaw et al.'s (2013) study noted that female employees with a history of drug use were stereotyped as sex workers. Evidence for stigma on behalf of healthcare workers is mixed, with some clients reporting they experienced care and warmth from healthcare workers, whilst others experienced them as cold, rude, and denying adequate pain medication (Earnshaw et al., 2013). Stigma also existed around the use of Methadone itself, with clients believing that the public simply did not understand what MMT was and what it was used for, a sentiment also expressed by a participant in the current study. Clients believed that some saw it as a treatment for an illness, whereas others saw it as continued drug use by the client, viewing those on MMT as not 'clean' from drugs, a view also held by some other substance users (Earnshaw et al., 2013). Some substance users' perceptions that Methadone replaces one drug for another further reflects the socially constructed hierarchy of drugs, indicating the extent of social construction in the area of drugs and drug treatment.

The subsequent sections will discuss gendered aspects of selected treatment options<sup>25</sup> for problematic substance use. This frames the discussion on the gendered nature of substance use treatment, and the need for providers to take this into account when designing and providing treatment.

### **Treatment Options as Gendered Experiences**

Treatment options for SUDs vary and include psychological, behavioural and social interventions, as well as medicated treatments. These treatments can occur in different settings including community, partial hospitalization and residential treatment (NIDA, 2014).

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<sup>25</sup> Due to space limitations, this discussion will focus on selected treatment options attended by women in the current study, and which research indicates are particularly gendered. This is not to detract from the fact that all treatments and treatment experiences are in some way gendered. The focus on certain, obviously gendered treatments, offers clear examples.

## Long-Term Residential Treatment

Long-term residential treatment was attended by several of the women in this study, and provides 24-hour care, usually in a non-hospital setting (NIDA, 2012). One of the most well-known forms of this form of treatment is the therapeutic community (TC; NIDA, 2012). TCs aim to re-socialise the person back into the community, actively incorporating the whole community in treatment. ‘Addiction’ is viewed in the context of an individual’s social and psychological experiences, with treatment focusing on developing individual responsibility and accountability, as well as teaching skills to allow individuals to live socially productive lives (NIDA, 2012). This reflects some awareness of the social and cultural determinants of problematic substance use. These treatments are often comprehensive, offering skills in important life domains such as employment (NIDA, 2012). Systematic reviews produce mixed results for the effectiveness of TCs, with Vanderplasschen et al. (2013) concluding that TCs can promote changes in various outcome categories such as substance use and legal outcomes, employment, and psychological function. However, they also note the importance of continued care after treatment. These findings are echoed by Magor-Blatch, Bhullar, Thomson, and Thorsteinsson (2014), suggesting a general effectiveness as a therapeutic intervention. However, effectiveness studies of TCs for women are mixed, emphasizing the need for a gendered approach to substance use treatment (Eliason, 2006). It may be that aspects of the TC are more compatible for men than women, with the confrontational nature of TCs<sup>26</sup> not suited to some women, particularly those with a history of negative mental health and abuse experiences

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<sup>26</sup> TC’s involve total emersion into the community, involving constructive confrontation and feedback. Group members confront each others’ negative behaviour and attitudes to create an open and safe environment (Eliason, 2006).



(Eliason, 2006). Women also often communicate indirectly, using subtle tones and being less decisive (Turney & Sitler, 2012), which is in confrontation with the direct nature of TCs, making the environment a negative one for some women (Eliason, 2006). Whilst it is possible to remodel the TC to reduce its confrontational nature and be more gender-sensitive, it then raises the question as to whether it is then still a TC (Eliason, 2006). As argued by Eliason (2006), it may be more effective to develop programmes specifically for women, rather than to apply and then modify male-developed programmes. This need to develop programmes specifically for women is also seen with family and couples therapy, discussed next.

### **Family and Couples Therapy**

Family and couples therapy is an often-utilized approach, with family therapy frequently used in the treatment of adolescents with substance use problems. Some studies have also found family therapy to be useful with adult populations (Carroll & Onken, 2005; Liddle & Dakof, 1995), however, overall success rates are mixed (Liddle & Dakof, 1995). PDU's, particularly women, are often estranged and isolated from support systems and family members (Schäfer, 2011), which may contribute to a limited effectiveness with adult populations, as they do not have the support systems to utilize this treatment. These approaches treat substance-using individuals within their families and other social contexts acknowledging the importance of social and cultural factors in substance use (Carroll & Onken, 2005; Liddle & Dakof, 1995). Fals-Stewart, O'Farrell, and Birchler (2001) demonstrated the effectiveness of couples therapy in males receiving Methadone, evidencing that including family members or significant others in treatment may help to reduce attrition rates and provide a platform to address multiple issues (Carroll & Onken, 2005). However, success rates for women may differ due to their increased likelihood of experiencing abuse, particularly from partners. Family and couples therapy can be

quite diverse, with a lack of consistency across providers (Liddle & Dakof, 1995). Therefore, efficacy will differ between approaches. They are frequently combined with other aspects of substance misuse treatments such as individual counselling and skills training, which will also impact their efficacy (Carrol & Onken, 2005). Combining these approaches suggests that a holistic approach is necessary for effective substance use treatment to improve client satisfaction, although, more non-traditional treatment aspects are also important in holistic approaches<sup>27</sup> (Breslin, Reed, & Malone, 2003), an aspect also identified by women in the current study.

### **Twelve-Step Models**

Perhaps the most well-known treatment options for SUDs are the twelve-step abstinent<sup>28</sup> models of AA and Narcotics Anonymous (NA). These approaches are spiritually-based, which has generated controversy (Dossett, 2013), but they have demonstrated effectiveness for some individuals. AA and NA employ the Disease Model to explain SUDs and view SUDs as chronic, life-long conditions (Larson, 2015). AA and NA are voluntary, mutual self-help groups, whereby members help and support each other to achieve and maintain sobriety from addictive substances by following the 12-steps (Bond, 2013; Dossett, 2013). These 12-steps are a suggested practice to help the individual resist the urge to use substances and build a better life through a spiritual awakening (Bond, 2013). Maltzman (2008) claims that part of what makes AA work is its platform to share emotions and make social connections, demonstrating the importance of social

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<sup>27</sup> For example, art classes, exercise, recreational activities and vocational services (Breslin et al., 2003).

<sup>28</sup> As discussed throughout this thesis, abstinence may not be the goal for all substance users, and may in fact deter them from treatment (Witkiewitz, 2013). Research suggests that moderate, reduced consumption of substances is possible for some substance users (Witkiewitz, 2013), and that substance users may be able to adequately choose the best treatment goal for themselves (Lozano et al., 2015). Abstinence can also be difficult to maintain, and generates ambivalence in the substance user, resulting in substance users dropping out of treatment (Palmer, Murphy, Piselli, & Ball, 2009).

relationships in substance use treatment, a component also identified by women in the current study. The importance of social relationships and social capital for integration and reintegration after substance use was also noted by Buchanan (2011). Through ‘working’ the 12-steps, and with the support of peers at meetings, individuals come to achieve sobriety. Attending meetings with other recovering substance users is said to be the most important aspect of AA for new members.

Effectiveness studies for AA are inconclusive, with some studies supporting its efficacy, and others claiming it is no better, and sometimes worse, than alternative treatments on several outcome measures (Tonigan, 2008). Gendered options for women have been suggested to be more appropriate and successful for women, with women-only AA groups growing in popularity during the late 1960s and early 1970s. Researchers found that women felt they were better able to express their emotions, share more, and were more able to talk about family relationships and sexual problems than in mixed-sex groups (Vourakis, 1989). These feelings were also expressed by women in the current study, indicating the continued popularity of women-only groups. However, despite its success for many, AA has been criticized on several points, particularly in relation to gender.

Criticisms of AA center around four key areas: 12-step spirituality thinly disguises religion, 12-step spirituality is inherently disempowering for women, 12-step spirituality is exclusive to non-Judeo-Christian or post-Christian worldviews, and framing the problem as a spiritual illness with a spiritual solution further judges and stigmatizes the individual, and perpetuates the sense of powerlessness over the problem (Dossett, 2013). It is argued that, whilst AA asserts its independence from an organized religion, many aspects of a meeting and wording in the texts are inherently religious (Dossett, 2013). The criticism that AA is inherently

disempowering for women is founded on four perspectives. The patriarchal literature is seen to be oppressive, and clearly reflects the language of the 1930s (Dossett, 2013). The concept of AA and the texts were conceived and written by men, for men, and male pronouns are used throughout. Secondly, the religious language is also patriarchal, God is male, and referred to as father (Dossett, 2013). Powerlessness is central to the third perspective, with 12-step programmes claiming that one cannot overcome their addictions without admitting their powerlessness over the substance (Bond, 2013; Dossett, 2013). As discussed above, many women with SUDs have experienced abuse, leaving them feeling powerless over their situation, and their bodies, therefore, having to submit to powerlessness in AA may further subordinate women, resulting in a reminder of their abuse. It is asserted that women are inherently powerless in society, dominated by the male perspective and influence (Dossett, 2013). The inherent powerlessness of AA perpetuates victimhood for many women with SUDs (Bond, 2013; Dossett, 2013; Unterberger, 1989). Further, traditional Christianity favours conservative, home-making roles for women which may increase feelings of gender role failure and stigma (Aune, 2008). Christianity also aligns itself against same-sex relationships and marriage, alienating specific groups in society (Subhi, & Geelan, 2012). The fourth perspective is that of the second-wave feminists who believe that AA cannot be apolitical as it claims, because, an organization that is not committed to elevating women and women's rights perpetuates patriarchal oppression (Dossett, 2013).

Despite some feminists' arguments that AA is oppressive, male-dominated, patriarchal, and uses a one size fits all approach, research suggests that many women do find value and empowerment from AA, and can achieve sobriety through this method of 'treatment' (Bond, 2013; Sanders, 2006; Sanders, 2011). Women also come to define themselves, not as victims of

their substance misuse, but as individuals who have the ability, courage, and power to overcome their substance use (Sanders, 2006). These criticisms also fail to explain that one-third of AAs membership are women (Bond, 2013). Sanders (2006) found that women adapted the 12-steps to fit their specific, gender-determined needs. In her study of women in AA, Bond (2013) found three themes in relation to women's navigation of AA. Women were found to navigate the paradoxical language of AA to achieve healing (Bond, 2013). Women in Bond's (2013) study also adapted and re-appropriated the male language of AA to suit their recovery, as well as creating a community of women in AA, found through women-only groups to generate bonds and connections, fostering healing and empowerment (Bond, 2013). Women in Larson's (2015) study also identified the importance of connections with others, particularly other women, in their recovery. This suggests that AA offers peer support in ways that individualistic treatments and therapies such as individual counselling do not, further supporting the importance of a holistic approach to effectively supporting women who problematically use substances.

Connections and support formed in group treatment were also important to women in the current study, which is discussed further in Chapter Six. The women in Bond's (2013) study argued that the powerlessness they had to admit over alcohol was not equivalent to admitting powerlessness over other life aspects (Bond, 2013), and many of these women also felt safer in all women's groups and felt more trusting (Bond, 2013). The opportunities to learn from other women who have had the same experiences was a significant reason for attending women-only AA groups for the women in Sanders' (2011) study, as well as a common theme in Larson's (2015) study, and was an important experience for the women in this current MA thesis. Women can also take

what works for them from AA programmes and develop their own approaches to this kind of treatment (Covington, 1994, as cited in Bond, 2013)<sup>29</sup>.

### **Women-Only Groups**

Women-only groups have become increasingly popular in recent decades. These exist in the AA community (discussed previously), as well as community alcohol and drug settings and in residential treatment facilities. Women-only groups are often less confrontational and more supportive than traditional mixed-gender groups in light of lower the self-esteem experienced by substance-using women (Grella, Polinsky, Hser, & Perry, 1999). These groups focus on empowering women to make changes in their lives by providing them with social, vocational, parenting and education skills (Grella et al., 1999). Efficacy studies suggest mixed findings: some women have experienced better treatment outcomes in women-only treatment compared to mixed-gender groups, whilst others have not, or have experienced no differences (Grella, et al., 1999). Consistently, women-only groups provided services specifically for women, such as pregnancy and parenting help (Grella et al., 1999), and they were more likely to provide parenting classes, pediatric, prenatal and postpartum services, and children's activities than mixed-gender groups. They were also less likely to charge a fee or accept third-party payment than mixed-gender groups, reflecting an acknowledgment that women entering substance misuse treatment have a lower economic status than men (Grella et al., 1999). Women-only groups were also more likely to provide practical assistance such as transport, housing and job training

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<sup>29</sup> Jean Kilpatrick developed Women for Sobriety (WFS), consisting of 13 steps, reworked from AAs 12. WFS 13 steps aim to enhance women's self-esteem, which Kilpatrick believes was not addressed in AA, along with the social stigma attached to women who problematically use substances, or the shame and guilt surrounding it (Unterberger, 1989, Bond, 2013). The original 12-steps and Kilpatrick's 13 steps can be found in Appendix A.

(Grella et al., 1999). Some studies have found that women in mixed-gender groups have experienced sexual harassment from male group members. This not only undermines treatment, but may trigger those who have had past experiences with abuse (Brown, 2009). Some women experience harsh and blaming treatment in mixed-gender groups which can reinforce their distrust of treatment providers and decrease their willingness and likelihood of using services (Brown, 2009), highlighting the importance of women-only groups. As with the other treatment options described, those seeking treatment will have individual needs and preferences for treatment and the services they attend, not all women will want to attend women-only groups. Women-only groups are not homogenous, therefore, not all women-only groups will be suitable for all women (Vourakis, 1989). For example, Vourakis (1989) compared women's participation in all-women versus mixed-sex AA groups, finding that personal, group and structural factors interacted in recovery to determine group choice, and that group choice changed over time depending on the women's stage of recovery and their personal growth. These women were seeking what Vourakis (1989) termed 'groups like me,' groups in which members shared similar experiences or stages of recovery, rather than necessarily being based on the sex of group members.

MMT can also be experienced as a gendered programme, although, women in the current MA study did not identify their experiences as gendered, indicating that treatment experiences vary between women.

## MMT

MMT originated in the United States with a clinical trial investigating the feasibility of treating those addicted to Opioids with Methadone<sup>30</sup> (Center for Substance Abuse Treatment, 2005). In 1962, Dole, Nyswander, and their team of researchers tested various Opioids for their suitability for maintaining clients' dependent on Opioids. The aim was to find a suitable substitute for the users' drug of choice, which would reduce their use, whilst enabling them to become a 'functioning' member of society (Center for Substance Abuse Treatment, 2005). Maintenance therapies effectively reduce the harms of injecting drug use, including the spread of infectious diseases such as HIV, as well as other injecting-related health issues, and reductions in illicit drug use are also evidenced, along with reductions in criminal activity (Strain, Stitzer, Liebson, & Bigelow, 1993). MMT seeks to assist PWUD to remain healthy until they can receive the care needed to live a life free of dependence. MMT is a harm reduction approach, as opposed to abstinence-based treatments.<sup>31</sup> Harm reduction aims to reduce the harms associated with drug use<sup>32</sup>, and include initiatives such as needle and syringe exchange programmes (Hunt, 2003). Harm reductionists believe that all substance use is potentially harmful, but that these harms can be reduced, with a focus on reducing these harms, rather than preventing substance use per se (Hunt, 2003). Harms associated with drug use include overdose, wound infections from injecting,

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<sup>30</sup> Methadone is a synthetic opioid agonist which binds to receptor sites in the nervous system (Hunt, 2003).

<sup>31</sup> Although, this is debatable, as abstinence from substances other than Methadone is often required on MMT.

<sup>32</sup> Harm reduction as an approach to alcohol and other drugs has also been criticised for focusing on the individual and their behaviour change, rather than acknowledging the wider risk environment that those using alcohol and other drugs inhabit. Harm reduction is also criticised for not acknowledging the pleasures involved in substance use, and for privileging middle class values of moderation and restraint (Miller, 2001; Keane, 2009, Rhodes, 2009).



criminal elements, and death. These harms can occur at various levels including individual, community and social, and take different forms including social, health, and economic harms (Hunt, 2003). Harm reduction programmes are argued to be consumer-centered, and actively involve consumers in the design of their programme. Programmes are theoretically about choice rather than coercion, with consumers encouraged to voluntarily make decisions about their treatment and drug use, maintaining their dignity and autonomy (Erikson, Riley, Cheung, & O'Hare, 1997; Hunt, 2003).

The effectiveness of Methadone is often dependent on programme and clinic factors. The most effective clinics have been identified as those which prescribe higher doses of Methadone, have an ongoing maintenance treatment goal, rather than abstinence-based, have a flexible dosing scheme, have better quality counselling and medical treatment available, better staff-patient relationships, low staff turnover and good management (Farrell et al., 1994). These are all factors which also influence the patients' experiences with and opinions of the maintenance services they attend. As will be discussed, consumer perspectives are a relatively new area of research, but provide valuable information to potentially improve services (Harris & McElrach, 2012; Montagne, 2002; Williams, 2002).

Despite its positive aspects, MMT is shrouded in a significant amount of stigmatization and negativity (Deering et al., 2011; Vanderplasschen, Naert, & De Maeyer., 2014; Woods, 2001). Various ethical arguments have been raised, particularly that clients are simply replacing one drug for another (Caplehorn, Lumley, Irwig, & Saunders, 1998), perpetuating the stigma associated with MMT, and the tasks involved, such as supervised consumption. Anstice, Strike, and Brands, (2009) described how having to attend a pharmacy regularly to drink their Methadone left many clients feeling stigmatised and open to public judgment. Direct interview extracts from MMT

clients were used to describe their experiences and perceptions of stigmatization and MMT. Research in this area of client perceptions has highlighted both positive and negative aspects of MMT and clients describe how MMT has saved their lives, returned stability, enabled stable employment and education, and helped them work towards mending relationships (Joseph, 1995). Woods (2001) highlighted how some of the worst stigmatization came from the programme staff themselves, as several staff members are seen as ambivalent towards Methadone treatment. A number of programmes also administered sub-therapeutic doses to clients whilst other studies described how clients find the healthcare they receive to be judgemental, condescending, disrespectful and unresponsive to their individual needs (Trevor, 2011).

PWUD may also feel stigma in themselves, viewing treatment as a failure in self-management and self-control (Room, 2005). Clients were reluctant to trust medical staff because of the potential repercussions of breaking clinic rules, and fears surrounding breaches of confidentiality (Treloar & Rance, 2014). Clients have described trusting medical and clinical staff 'to a point,' with this lack of trust likely to hinder client outcomes (Treloar & Rance, 2014). Research suggests that this distrust is mutual, with clinic and medical staff viewing clients as inherently deceitful drug users (McCormick, Bryant, Sheridan, & Gonzalez, 2006; Treloar & Rance, 2014). Some community pharmacists viewed clients as abusive and dangerous, as well as increasing the likelihood of burglary (McCormick et al., 2006; Trevor, 2011). Clients are often seen as undeserving, with their health issues the outcome of their own poor choice (Treloar, Rance, Yates, & Mao, 2015). Other points of concern and dissatisfaction among clients include the high level of stigma surrounding MMT, as well as the inflexibility of the programme, lack of takeaway doses, long waiting times or waitlists, and a lack of input into their programme and treatment (Deering et al., 2011; Deering, Horn, & Frampton, 2012; Madden, Lea, Bath, & Winstock, 2008).

Clients are resentful of the restrictive requirements, put in place to control the non-compliant clients (Joseph, 1995). Such restrictive requirements give merit to the perceptions of some clients, as well as human rights campaigners, that MMT is a form of social control (Des Jarlais, Paone, Friedman, Peyser, & Newman, 1995; Harris & McElrath, 2012). Bourgois (2000) suggests that MMT is a tool for the State to enforce moral discipline upon ‘deviants,’ who are seen as rejecting sobriety and the opportunity to contribute to society’s economic productivity. According to Bourgois (2000), the state has created a difference between Heroin and Methadone, based solely on moral grounds to control pleasure and productivity. Essentially, the criminal justice system and medical authorities discipline individuals for their uses of pleasure, defining some substances as legal, and others as dangerous (Bourgois, 2000). It has been suggested that MMT is more similar to the criminal justice system than it is to a medical intervention (Treloar & Rance, 2014), with the need for daily or multiple visits to clinics or pharmacies, within strict periods, and the requirements to remain entirely drug-free on many of the programmes providing fuel to the social control argument. These restrictive requirements have led to MMT being referred to by some clients as ‘liquid handcuffs’ (Vigilant, 2001). Others have referred to Methadone as a ‘ball and chain,’ and as making them feel like robots (Bourgois, 2000). These points of concern and dissatisfaction can seriously impact treatment uptake and retention (Deering, Sellman, & Adamson, 2014), often contributing to the client internalising the ‘junkie’ or ‘addict’ Master Status<sup>33</sup>, an identity often attributed to drug users by non-drug users (Harris & McElrath, 2012). This Master Status can come to define all aspects of the individual’s life, to the point that they become the Master Status, rather than being seen as a human being (Lloyd, 2013). Nonetheless, other researchers report that

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<sup>33</sup> Master Status is a gendered term, ‘master’ traditionally used to refer to the masculine. This use of a gendered term may further stigmatise and delegitimise female substance users.

the majority of their participants have been satisfied with their treatment on Methadone overall (Deering et al., 2012; Madden et al., 2008), a sentiment echoed by Methadone clients in the current study.

### **Women and MMT**

Whilst the above studies have significantly contributed to the literature available on clients' experiences on MMT, the majority of these studies were conducted with male participants or a mix of male and female participants and researchers. As mentioned previously, female experiences and perspectives have been considerably neglected in research (Gibson, 2016; Rubio, 2013). Nonetheless, a select few studies exist examining female perspectives of treatment, and even fewer examining female experiences on MMT (Rubio 2013). Through the course of semi-structured interviews with women enrolled in a Methadone treatment programme in the United States, Rubio (2013) found that participants identified both positive and negative perceptions of Methadone. Positive perceptions included that being on Methadone allowed women to attend work, and take better care of themselves and their homes, some clinic staff were very supportive of recovery, and some of the women interviewed were looking forward to the positive effects of being on Methadone. These women praised Methadone for giving them the ability to take control over their own lives, for themselves (Rubio, 2013). Some women were also very willing to recommend Methadone treatment to other women (Rubio, 2013). Negative perceptions of Methadone treatment included that it was a legal replacement for other drugs, and is just as addictive and difficult to stop, some women starting on Methadone because it was a cheaper alternative to street drugs (Rubio, 2013). Concerns were also expressed about coming off Methadone, and the withdrawal process (Rubio, 2013), an issue also raised in the current study. An earlier study by Zajdow (1999) found that women had far less positive experiences on MMT. According to Zajdow

(1999), none of the women she interviewed chose Methadone because they wanted to, but did so out of fear of arrest and getting caught with illegal drugs. The women she interviewed were not part of a Methadone clinic, but received a doctor's prescription filled at a chemist. Zajdow (1999) saw this as simply drug treatment on a budget. Whilst Zajdow (1999) acknowledges that many women choose MMT for themselves and benefit positively from it, she believed the women in her study did not. One of the women described how the lack of group treatment and support left her feeling stigmatised and lacking group reinforcement and validation (Zajdow, 1999), a contrast to the positive support and connections formed by members of AA, discussed earlier. The experience of Zajdow's (1999) participant highlights the importance that connections over shared experiences can have in drug and alcohol treatment. Another woman also described how her physical symptoms and side effects were ignored by health professionals, an experience also discussed by a woman in the current study, indicating its pervasiveness. Another describes how she was not given enough information about coming off Methadone and the side effects she would experience, which left her feeling like she had gone mad (Zajdow, 1999), also an issue experienced by a woman in the current study. Zajdow (1999) highlighted the individualising nature and lack of community that exists when Methadone is simply picked up from a chemist. Twelve-step groups and even Methadone clinics create an environment to enable connection and the possibility of meaningful relationships, something clearly lacking for the women in Zajdow's (1999) study.

Pregnant women on MMT also experience additional pressures and stigmatization. The concern of losing their child to child protective services is a significant barrier to help-seeking (Chen & Moriarty, 2010). They also experience a deep sense of self-judgment and low self-worth because of their drug use, and the impact this could have on their child (Chen & Moriarty, 2010). Drug-using women in some states in the United States have been prosecuted for using drugs and

causing harm to their unborn child, charged with child abuse or manslaughter if their baby is born ill, is miscarried or dies (Kampschmidt, 2015; McGinnis, 1990). Health providers in some states are also required to report pregnant women who use drugs (Association of Women's Health, Obstetric and Neonatal Nurses, 2015). Murphy and Rosenbaum (1999, as cited in Trevor, 2011) describe how pregnant clients they interviewed arrived at the hospital in labour and faced the stigmatization of being just another drug user. They also felt like they were being 'watched.' The treatment they received whilst in hospital increased the guilt they already felt about what their drug and Methadone use could have done to their child (Murphy & Rosenbaum, 1999, as cited in Trevor, 2011). Few women on MMT have a primary care provider or GP, many women experiencing perceived and actual barriers to accessing regular primary health care (Chen & Moriarty, 2010). Research indicates that an 'us' and 'them' disparity exists between primary healthcare workers and pregnant MMT clients, with staff showing disrespect for client autonomy and their motive for treatment engagement (Chen & Moriarty, 2010), linked to the double deviancy and stigma experienced by substance-using women. This is a sharp departure from the recommendation for multi-disciplinary, patient-focused treatment (Chen & Moriarty, 2010). Some women also reported inconsistent information about their condition and the impact of neonatal withdrawal (Chen & Moriarty, 2010). As a result, women often feel fearful, confused, and distrustful of services and professionals (Chen & Moriarty, 2010). Thus, pregnant women on MMT experience all of the stigma and concerns of MMT clients, with the added impact and stigma of being doubly deviant. Despite this, research, knowledge and support services are still lacking.

The literature reviewed in this section indicates that problematic substance use is a significant concern, and results in a considerable amount of stigma. This stigma is gendered, being far more pervasive for female problematic substance users than for males, and affects women's

ability to, and likelihood of seeking treatment for their problematic substance use. It is also linked to the social and cultural construction of drugs and drug users. Female problematic substance users also experience gendered barriers to treatment entry such as childcare constraints and experiences of abuse, which affect their treatment completion. There are various treatment options available, with their effectiveness influenced by a multitude of factors, however, gender-sensitive treatments are highly beneficial, and more of these approaches are required. The reviewed literature suggests that experiences of substance use and substance use treatment can be significantly gendered, with women experiencing substance use, its effects, and treatment for it differently than men, necessitating further research into women's experiences of substance use treatment, and what improvements are required.

The research undertaken for this thesis attempts to fill the gaps identified throughout this literature review, examining the gendered nature of substance use and treatment, arguing for gender-sensitive and gender-responsive treatments to be more readily available in New Zealand. The following chapter details the methodological framework used to achieve this aim.

### **Chapter Three: Methodological Framework**

This research sought to examine women's experiences of alcohol and drug treatment in New Zealand, gathering data in their own voices, and of their thoughts on what needs to change about the way alcohol and drug treatment is provided to women. Originally, the research set out to explore the experiences of women on Methadone; however, severe difficulties in recruiting participants saw the research area expanded to all alcohol and drug treatment. Giving these women a voice when they had historically been ignored and stigmatised in a male-dominated arena was paramount to this research. A qualitative approach within a feminist framework seemed the most appropriate, with this chapter detailing the methodological and theoretical underpinnings of this research.<sup>34</sup> This research is exploratory in nature, seeking to provide a foundation for future work, and addresses a significant gap in the research and understanding of female experiences of substance use treatment.

#### **Theoretical Perspective**

##### **Feminist Perspectives**

This research sought to document the experiences of New Zealand women who have received drug and alcohol treatment. Underlying this was a desire to give these women a voice, to privilege their experiences and give value to their thoughts, opinions, and feelings. These women are a valuable resource to improve drug and alcohol treatment in this country, but they lacked a platform to express their insider knowledge. I wanted this project to instill a sense of empowerment in these women, to make them feel heard, validated, and above all, comfortable and safe in sharing their experiences.

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<sup>34</sup> Gibson's (2016) thesis informed the structure of this section with its similarities to the current study. Gibson's thesis was feminist-informed, like the current study, and aimed to give women a voice.



Developing to challenge the traditionally masculinist ways of doing and thinking about research, gender, and the way knowledge is produced (Doucet & Mauthner, 2006; Hussain & Asad, 2012; Ramazanoğlu & Holland, 2002), feminist research emphasises the need for participants to have their voices heard, to hear their lived experiences and value their personhood (Hesse-Biber, & Piatelli, 2007; Sprague, 2005). Feminist research should not just be about women, but for women, and with a view of wider social change and social justice (Doucet & Mauthner, 2006; Wambui, 2013). Women's needs and voices have been, and continue to be neglected in drug and alcohol research (Gibson, 2016; Rubio, 2013), however, feminist perspectives seek to place women in a more acknowledged position and examine the ways in which gender informs and interacts with substance use and women's experiences (Ettorre, 2007; Gibson 2016). Research that has examined women in the drug economy has focused on the pathology of their drug use and their powerlessness in the environment (Anderson, 2008). Yet, women in the drug economy have power and influence in many ways, with Anderson (2008) arguing that women often hold the male-dominated economy together.

Given the double-deviancy stigmatization faced by women who use drugs and alcohol (Gibson, 2016), and the hard to reach, distrustful nature of the drug using population (Levy, 2014), women who have sought treatment for drug and alcohol issues could be considered a sensitive population (Flaskerud & Winslow, 1998; Gibson, 2016). A feminist perspective and framework aims to look after the interests of marginalised and stigmatised populations, with a core tenet of feminist research to inflict no harm (Gibson, 2016; Liamputtong, 2007). This vow to inflict no harm aligns with the necessity to protect the mental and physical wellbeing of vulnerable and sensitive participants (Gibson, 2016; McCosker, Barnard, & Gerber, 2001), and a way of researching that is non-hierarchical, non-exploitative and participatory (Hesse-Biber, &

Piatelli, 2007; Wambui, 2013). A feminist perspective can aid understanding of the issues faced by women who use drugs and alcohol (Anderson, 2008; Gibson, 2016), and as such has become more recognized for the role it plays in acknowledging the diverse and complex experiences of female substance users (Gibson, 2016; Olszewski et al., 2009).

### **Methods**

Semi-structured interviews were used for this research because they allowed women to be flexible in their answers, decline to answer questions they did not wish to answer, and discuss additional aspects they felt necessary in a safe environment (Gibson, 2016; Sutton, 2011). The methods used aimed to explore the experiences of women who are currently, or had previously attended some form of drug and alcohol treatment in New Zealand. Service providers who worked with women in alcohol and drug treatments were also approached to gain their perspectives on women's experiences in alcohol and drug treatment and how services could be improved to better suit the needs of women.

The way participants are asked about their experiences, and the way the research is designed can limit their responses, restricting the understanding of their subjective realities (Briggs, 2015). Therefore, it is important to allow participants scope and ability to fully share their stories. Three interview guides were utilised (see Appendices B, C, and D), one guide was only employed for a single interview (the first participant who was on Methadone and entered this research in its original stages). For the remaining participants, one guide was used for those who are currently, or had previously attended drug and alcohol treatment in New Zealand, with the third guide used for treatment providers. These guides provided questions to prompt and encourage participants in their responses, but they did not restrict discussion. Participants were free to add additional information sparked by the questions, as well as jump back and forth

between questions. The use of these guides ensured that the key research areas were addressed in each interview, and kept both the participants and this research on track during discussions.

Qualitative research methods are a valuable tool, not only because they provide more in-depth information, but because they allow drug and alcohol use, particularly women's experiences, to be viewed within the context that it occurs, and allows for the de-stigmatisation of drug and alcohol use (Gibson, 2016; Taylor, 1998). For example, Taylor's (1998) ethnographic study of female injecting drug users demonstrated that her participants were not the stereotyped 'pathetic' individuals, but were independent, resourceful women who were able to make a life for themselves. Taylor (1998) provided a forum for these women to explain their experiences from their own perspectives, rather than a privileged outsider inferring knowledge. Traditional research methods and perspectives privilege the researcher, denying participants the ability to adequately express their experiences (Gibson, 2016; Sprague, 2005). Whilst feminist research places the participant at the fore of the project, taking a feminist perspective also acknowledges the impact that the position of power held by the researcher can have on the participants and the research (Ramazanoğlu & Holland, 2002; Sprague, 2005). Sprague (2005) details the three main aspects of power that the researcher has in the research process. The researcher has more power over the research process and how the relationship between researcher and participant is constructed. The researcher also determines what is studied and how the data will be collected, they decide how to analyse and interpret the data, and how it will be represented to others. Researchers also choose what aspects of transcripts best suit their reporting needs, and where the final report will be presented (Sprague, 2005). Researchers often come from a more privileged social position, and by determining the topic of research, what they see as worthy and important, they are by default, deciding what is not important (Sprague, 2005).

Feminists reject this power hierarchy, emphasising the importance of information sharing through the personal involvement of the researcher in the research setting, not simply to gather data (Hussain & Asad, 2012). Feminist methodologies reject objectivity on behalf of the researcher, questioning how objectivity can contribute to women's empowerment when it subordinates them (Driscoll & McFarland, 1989). Instead, feminist researchers attempt to actively involve participants in the research process (Liamputtong, 2007; Westmarland, 2001). In attempting to address these issues, I let participants know that this was the first time that I had conducted qualitative research, and that, although I have a relatable background in some respects (mental health), I was an outsider when it came to drug and alcohol use (Dwyer & Buckle, 2009). In interviews with those who also discussed co-occurring mental health concerns, I disclosed my own history of mental health, hoping to put them at ease. Self-disclosure is a powerful and essential part of qualitative research with vulnerable populations, helping to build trust and rapport, as well as reduce the power imbalances (Liamputtong, 2007). Some researchers argue that self-disclosure may cross ethical boundaries and could be exploitative of participants, whilst others believe it is up to the researcher to decide if and what they disclose (Liamputtong, 2007).

When contacting participants, I also disclosed that I was a master's student, therefore, somewhat explaining my relative privilege. In doing so, I hoped to reduce the power imbalance that can exist between the researcher and participant (Harding and Norberg, 2005; Liamputtong, 2007). Surprisingly, making this known did not appear to impact the way these women interacted with me or responded to questions, with many thanking me for undertaking this research and wishing me luck. I was also given the opportunity to take part in group sessions at a treatment facility I was invited to visit. This was a humbling experience, which I felt

privileged to be part of. To be granted access to these women's personal lives and safe environment made me feel nervous and apprehensive, but also trusted and welcomed. It allowed me to also share a piece of myself in that group, facilitating trust to develop between myself and the women I interviewed. Despite being a stranger, I was welcomed into the group and made to feel at home. This building of trust and rapport is crucial in the research process, particularly when researching vulnerable populations as the existence of trust and rapport may facilitate more informed research (Liamputtong, 2007). Sharing an ethically balanced amount of personal detail with the participant aims to increase reciprocity between interviewer and participant, as well as create a welcoming and safe environment (Dixon-Swift, James, Kippen, & Liamputtong, 2007; Gibson, 2016). The research process itself can also confer power imbalances, with the researcher given the power to determine the theories, methodologies, and lenses applied to the data (Gibson, 2016; Harding & Norberg, 2005; Sprague, 2005). As Gibson (2016) explains, because of these inherent power imbalances, it is crucial that research with marginalised and sensitive populations chooses methods and methodologies that put to the fore participants' voices and experiences.

Researcher reflexivity is crucial in qualitative research (Gibson, 2016; Hesse-Biber, 2007; Ramazanoğlu & Holland, 2002), ensuring the researcher is aware of their own position in the process, and that of the participant. It aims to make explicit the power relationships existing within the research, enabling honest discussion and communication. Reflexivity also helps to protect and respect the participant's mental and emotional wellbeing through techniques in interviews such as allowing them enough time to express their emotions and reinforcing the importance of their wellbeing (Gibson, 2016; McCosker et al., 2001). Reflexivity was an aspect I was aware of before embarking on this research and was also something that caused me significant anxiety throughout this process, as I considered whether I was doing it 'right.' I

endeavoured to be empathetic and understanding when negative experiences or emotions arose from participants, and encouraging and supportive of their positive experiences and life-changing moments. I feel that by doing this I could validate these women's feelings and experiences, as well as provide them with encouragement to continue their positive lifestyle changes.

### **Recruitment**

Recruitment was initially very difficult when seeking participants who were or had been on Opioid Substitution Treatment. The Wellington Methadone Clinic, run through the Capital and Coast District Health Board (CCDHB) were not happy to advertise my research at the clinic due to the vulnerable nature of their clients. Whilst this made recruitment difficult, their reluctance to assist with this research came from a place of concern for their vulnerable clients and protecting their wellbeing. I also approached various pharmacies that dispense Opioid substitutes about my research and asked if they would display my poster (see Appendix E) who were obliging and agreed to either put up my poster or mention the research to potential participants.

With no participants forthcoming from the pharmacy recruitment or the Methadone Clinic, I also approached the Wellington Needle Exchange (Drugs and Health Development Project-DHDP), who were more than willing to put up my poster and mention the research to potential participants, although, unfortunately, none were forthcoming. Utilising social media proved fruitful in recruiting my first participant (for the wording of the Facebook post see appendix F), who was an existing acquaintance. The research poster was distributed via a public post on my own Facebook page, which could then be seen and shared by anyone. My own privacy was protected as all security settings on my account were set so that nothing else was

shown about me if people chose to look at my profile. This was the one and only participant recruited under the original scope of the research (Opioid Substitution Treatment).

Facing difficulties, and having only one participant, the scope of the research was expanded to include women who were or had been receiving any form of alcohol and drug treatment. To improve recruitment chances, and to increase the generalisability of this research, recruitment began outside of Wellington with the expanded scope. Broadening the scope proved successful, as did reaching out to service providers outside of Wellington. As mentioned above, PWUD, and especially WUUD, are a hard to reach and distrusting population (Levy, 2014), with a seasoned skepticism of outsiders. There are several barriers to recruiting from the PWUD populations (Griffiths, Gossop, Powis, & Strang, 1993), and although gatekeeping agencies may be utilised in aiding access to hard to reach populations, some may prove to be a barrier to access (Liamputtong, 2007). However, the majority of service providers I approached were supportive of this research and its potential benefits for women.

An amendment to the Human Ethics Committee application was sought and granted. I emailed various service providers via the contact information on their websites asking for their assistance in recruiting. These service providers were found through a Google search for drug and alcohol treatment in New Zealand. Many responded positively to my research, although there was some scepticism and concern for the welfare of their clients. Copies of the participant consent form and participant information sheet (appendices G and H) were sent in either the initial email contact (if this was possible) or were sent when a reply was received from the service providers. Proof of ethics approval (Appendix I), and in some cases the interview schedules were also sent if requested (see Appendices B, C, and D). All emailing was done through an official Victoria University of Wellington email address (the same one provided on

the poster-the only contact information provided). The use of this email address was to ensure participant confidentiality, as well as follow Human Ethics Committee requirements about researcher safety and confidentiality. Those service providers willing to support this research then passed my information and the paperwork onto their clients and either sent them to me on their client's behalf, or the clients did so themselves.

Potential participants who were interested in the research would then email me to organise a time to do the interview. The majority of these interviews were conducted via phone, as participants were located outside of Wellington. Once the interview was completed, no further contact was made with the participants via this number to satisfy Human Ethics Committee requirements. Having made contact with the clinical manager at one treatment facility, I was invited to spend the day there, interviewing the women in a face-to-face group interview. This face-to-face group interview yielded five women receiving treatment and one service provider interview. I was able to obtain the remaining participants (six) via the emailing of treatment providers. One of these six was also a service provider, who was happy to be interviewed as both a woman having received treatment and a service provider, taking the total of service providers interviewed to two. Thirteen participants were recruited in total<sup>35</sup>.

Using various recruitment techniques is common when attempting to access hard-to-reach populations (Liamputtong, 2007), and so, posters were also placed around Victoria University of Wellington campus. No participants were recruited via this method.

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<sup>35</sup> The recorder used for these interviews damaged the recording of the group interview and one service provider, and so, verbatim transcription of these interviews was not possible. Instead, an interview summary was written from memory as accurately as possible.



## Interviews

Informed consent from participants was crucial to this research, and all participants were given a copy of the consent form (Appendix G) which advised them that they were able to withdraw at any time up until May 30 2017, with their responses either returned to them or destroyed. All participants received a copy of the information sheet and consent form prior to the interview (see Appendices H and G). No interview took place until the consent form had been returned. Participants were advised that they may ask questions about the process if they wished, and could ask for the recorder to be turned off at any point. Pseudonyms were assigned to each participant (including service providers) to protect their identity and ensure confidentiality. The service providers' places of work were also not named to protect their identities, and protect them from potential professional consequences. In obtaining informed consent, all participants were made fully aware of the purpose of this research and what was required of them. Information about how and where their responses would be used was provided, and they were also given the option to receive a copy of the transcript, an interview summary, and a copy of the final report. In this way, these women were able to provide and receive feedback from the interviews, a way of giving participants respect and reciprocity (Liamputtong, 2007). The safeguarding of participants' privacy was paramount to this research, particularly because the discussions surrounded treatment for an illegal activity, which is highly stigmatised. Due to the potentially distressing discussions that may occur, contact details for confidential helplines and services were provided at the end of the information sheet, should the women wish to discuss anything that was brought to the surface in the interviews. Providing such information went some way to safeguarding the welfare of these women, along with confidentiality, privacy, and the use of pseudonyms. Protecting their welfare, and ensuring no

harm comes to participants is essential in qualitative research, particularly with vulnerable populations (Liamputtong, 2007).

As discussed, the primary method of data collection was through the semi-structured interviews with women who have or are currently receiving alcohol and/or drug treatment in New Zealand. Techniques considered feminist were utilised, avoiding traditional techniques which emphasise distance and objectivity. Trust, emotional connections, and understanding are crucial in feminist interviewing of sensitive topics and populations. Minimising status differences are important to obtain this trust, emotional connection, and understanding (Punch, 2005). I attempted to do this by making my email communications prior to the interviews friendly and open. I also introduced myself at the beginning of the interview and discussed why I was doing this research, along with discussing the topic and the questions I would like to examine. In several interviews, I discussed the importance of this research and my hopes for where it could lead, as well as discussing with the women my happiness at their own recovery and the joy they have found in their lives. On a few occasions, I mentioned to some women who had disclosed comorbid mental health concerns my own history of mental health issues (without going into specific detail). Interviews varied in length depending on the amount of discussion and information to share. One interview was over an hour long, yet another was completed in just over twenty minutes. On average, interviews were approximately forty-five minutes. As discussed, one interview was undertaken via Skype, using only the calling function (not video). This was at the request of the participant, who felt more comfortable this way. Six interviews were undertaken via phone. These were done from my own home in a private room. Five women who had, or are receiving treatment and one service provider were interviewed in person at a treatment facility. The women were interviewed as a group (at their own request) in the

room in which they attend group meetings, and the service provider was interviewed in her office. All participants received a \$20 supermarket voucher to thank them for their participation.

### **Thematic Analysis**

Thematic Analysis (TA) fitted this research well, its flexibility ideal for the complexities of feminist research (Braun & Clarke, 2006; Gibson, 2016). TA is independent of theory and epistemology, allowing it to be applied across a wide range of data (Braun & Clarke, 2006), although critics of TA claim that it has an ‘anything goes’ philosophy, with a lack of clear guidelines (Braun & Clarke, 2006). TA is a method of identifying, analysing and reporting themes contained in data (Braun & Clarke, 2006), and whilst widely used, there has been a lack of agreement about what TA is and how to do it (Braun & Clarke, 2006). Searching for themes across an entire data set, TA differs from other qualitative methods which look for themes within individual data items, such as a single interview (Braun & Clarke, 2006). Given my lack of experience and knowledge with qualitative research, TA was an ideal choice because it does not require in-depth technical and theoretical knowledge, like that of Grounded Theory, making it far more accessible (Braun & Clarke, 2006). TA calls for constant reflexivity on the part of the researcher, throughout the research process, which aligns with the feminist researchers’ emphasis on reflexivity. Further complementing feminist research, TA provides a rich, detailed description of the data set, allowing for women’s voices to be heard in their own words, privileging women’s voices within the aims of feminist research (Braun & Clarke, 2006; Gibson, 2016). TA allows for themes to be identified in two ways, a bottom-up, inductive approach, in which themes are strongly linked to the data, or the top-down, deductive, theoretical approach, linked more to the researchers’ interest in the topic (Braun & Clarke, 2006). The option for inductive theme identification supports feminist research’s aim of reducing the power imbalance in the research

process and the privileging of women's voices (Dixon-Swift et al., 2007), not imposing the researchers own ideas on the data. However, as Braun and Clarke (2006) note, it is difficult for the researcher to separate themselves from their theoretical and epistemological backgrounds. TA also allows for socially produced themes to be identified and explored (Braun & Clarke, 2006; Gibson, 2016), making TA appropriate for this research because gendered experiences are socially constructed (Gibson, 2016). A further criticism of TA is that it can be difficult to identify quotations that are representative and compelling, with the potential for the sense of the individual participant to be lost (Braun & Clarke, 2006; Gibson, 2016). Additionally, there can be a lack of flow and consistency when using TA, with the potential to clearly identify inconsistencies between accounts (Braun & Clarke, 2006; Gibson, 2016). The flexibility of TA can also be a disadvantage if data analysis is too broad, making it difficult to do a more advanced analysis (Braun & Clarke, 2006). Given its broad approach, TA can be problematic when it comes to interpretation if it is not linked with a theoretical framework (Braun & Clarke, 2006). This was kept in mind during analysis, ensuring the analysis adhered to feminist values.

For this analysis, I followed Braun and Clarke's (2006) six-step guide to TA. These six steps are: becoming familiar with the data, generating initial codes, identifying themes, reviewing themes, defining and naming themes, and producing a report of the results (Braun & Clarke, 2006; Gibson, 2016). The process for this research is as follows:

1. Data familiarity: All interviews were recorded on a digital recorder, with the file transferred to a computer. The recording was then listened to so that familiarity with the data could be obtained, and provide the opportunity to reflect on the interview process. Each interview (minus two interviews with the recorded files damaged) were then transcribed verbatim. Interview summaries were then created from these transcriptions to

summarise key points. These were then printed, along with the interview transcripts, which were read, reread and highlighted, with notes made regarding initial themes.

2. Generating initial codes: Systematically reading through each transcript identified five themes. Coding was achieved by highlighting data relating to each theme and writing the initial name of the theme beside that data.
3. Searching for themes: This was achieved by systematically reading through each transcript for themes, with coding done via highlighting and writing the name of the theme the data extracts related to. Some extracts could have been coded for more than one theme.
4. Reviewing themes: Themes were then discussed with the researcher's supervisor, with coded extracts reviewed to ensure they related to the identified theme. This process helped to support validity. Relevant verbatim quotes were placed in separate files for each theme to facilitate results reporting.
5. Defining and naming themes: Each of the five themes were then re-examined to identify and make sense of the women's specific experiences. As Gibson (2016) explained, this provided an overall sense of the theme. The themes were named and defined as: What is treatment, stigma, connections and relationships, knowledge and room for improvement<sup>36</sup>.
6. Producing the report: A selection of verbatim quotes were chosen. These significant examples were selected to give women a voice, explain, and provide an understanding of

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<sup>36</sup> Initially, five themes were identified, however, due to space constraints the four key themes were discussed. 'What is treatment' was removed from the final report, but crucial aspects were assimilated into the discussion in other chapters.

their experiences. These quotes were then further analysed, linking them back to the research questions for this thesis, and the literature informing the research.

Once initial codes were obtained (42), see *table 1*, these were reviewed to see how they could be reduced to key themes. I searched through the initial codes to determine which codes were similar and could be subsumed together, and how these codes related to the research questions. This process was completed twice (see *table 2* for refined codes), with names then generated for themes which incorporated these codes and best described the codes incorporated in the themes.

Table 1

*Initial Codes obtained through Thematic Analysis*

Initial Codes	
Demographics	General Practitioners
Treatment	Living Life
Contentions	Future Worries
Staff/Professional Support	Change Needed
Family Support	Funding
Friend Support	Group Environment
Employer Support	Holistic Recovery
Emotional Support	Shared Experiences
Cut Ties	Self-Awareness
Practical Support	Change Talk
Mental Health	Finding Friends
Physical Health	Finding Voice
Comprehensiveness	Validated and Valued
Feelings	Women's Needs
Motivations	Children
Rock Bottom	Options
Help	Communication
Self-Stigma	Self-Esteem
Stigma	Personal Growth
Goals	Coming Off
Lack of Knowledge	Safety

Table 2

*Refined Codes obtained through  
thematic analysis*

Refined Codes
Treatment
Support
Shared Experiences
Mental Health
Family/Friends
Motivations
Stigma
Lack of Knowledge
Holistic Recovery
Living Life
Women's Needs
Change
Positivity



### **Practical Limitations**

The relatively small sample size of thirteen impacts on the generalisability of this data, particularly because many of the women had attended the same treatment providers. However, generalisability was not a key aim of this thesis, but rather, giving voice to, and understanding the experiences and individual stories of women who are currently receiving, or have received alcohol or drug treatment in New Zealand. Furthermore, although women who identified as both New Zealand European and Māori were interviewed, no analysis was conducted on ethnicity and their experiences, with the focus being on gender. Examining ethnicity and class in relation to women's experiences of drug and alcohol treatment is beyond the scope of this thesis, however, further research could remedy this limitation, with the potential to provide interesting and meaningful outcomes. Most of the women in this study expressed their experiences as positive, and whilst this is encouraging to hear, it begs the questions as to whether this research attracted those who had positive experiences only, or if those who did have negative experiences were reluctant or fearful to share their stories.

### **Personal Challenges**

Completing this thesis was an emotional and at times stressful journey. I had underestimated the challenge of recruiting participants, and the amount of groundwork required to recruit. A lack of successful recruiting left me on the verge of withdrawing from this thesis, but the drive to share the stories that I knew were out there pushed me to continue. The stories these women shared of how their lives had changed for the better since entering treatment at times brought tears to my eyes. I could hear their strength and determination to persevere with their new positive life, and this encouraged me to ensure their experiences and thoughts were accurately described in this thesis. The imagery one woman created with her story of personal

change was heart-warming, and I found myself feeling proud and excited for her, despite our lack of acquaintance. The stories of those who also dealt with, or are dealing with mental health in their recovery touched a personal note with me. Although I was an outsider with regards to substance use issues, I felt that I could relate on some level with my own mental health history. I found myself reflecting on my own feelings during my struggles, and remember feeling many of the same emotions experienced by these women.

Whilst sharing these experiences of mental health struggles with some women, I understood this was not equivalent to my reaching an understanding of their lived experiences. I was cognisant of the inherent differences that existed between myself and the participants, stemming from our disparate cultural, geographical and social backgrounds. Researching sensitive populations requires acknowledgement of the need to negotiate these differences between the researcher and the researched (Gibson, 2016; Liamputtong, 2007). As the ‘outsider’<sup>37</sup> I attempted to mitigate these differences by developing a rapport through sharing some personal information and general conversation at the beginning and, often, end of the interview. Brooks and Hesse-Biber (2007) suggest that seeking shared attributes or experiences with participants can go some way to bridging differences. Despite sharing a want for better treatment options and experiences for women, as well as mental health struggles with some participants, I was far from reaching an ‘insider’ status. Although, Brooks and Hesse-Biber (2007) note that the lack of knowledge in the outsider position can be advantageous in its own right, allowing the researcher to ask questions about issues or experiences, where their knowledge may have been assumed if they were considered an ‘insider’ (Gibson, 2016).

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<sup>37</sup> An insider is a part of the topic being studied, someone who has some form of connection with those being studied. An outsider has no such connection to the topic of study (Sherry, 2012).

Although I can only imagine the potential stigma experienced by women seeking treatment for drug and alcohol issues, I encountered numerous examples of stigmatised stereotypes and thoughts whilst completing this thesis. Friends shared their opinions on why many of these women were ‘mental’ or ‘druggies,’ with a doctor explaining to me why he did not trust those on Methadone because they are drug-seeking, whilst trying to prescribe me an unnecessary, highly addictive pain medication. I found myself defending this research, these women, and their experiences, in some ways experiencing stigma as a by-product. This reflects what Goffman (1963) termed ‘courtesy’ stigma; whereby people experience stigma due to their interactions and closeness with a stigmatised population (Gibson, 2016). At times, I struggled to keep my emotions measured and to not take the stigmatisation personally, rather, as Gibson (2016) did, using it to reflect on what previous research indicated regarding stigma associated with women seeking treatment (Hecksher & Hesse, 2009; Raeside, 2003).

Research has demonstrated the toll that researching sensitive populations can have on the researcher (Dickson-Swift et al., 2007; Liamputtong, 2007), such as changes in emotion, sleeplessness, feelings of anger, and frustration (Dixon-Swift et al., 2007; Gibson, 2016). The interview process impacted me emotionally, particularly having to balance it with working full-time and personal commitments. Trying to schedule interviews and find a space to do so was challenging, with the back and forth far more taxing on my energy levels than anticipated. Finding time and motivation to transcribe and analyse the interviews was also taxing. The stress of recruiting also impacted me emotionally, with a significant amount of anxiety and frustration.

Throughout this research process, I have been eternally grateful and privileged for all of the women who have shared their stories and experiences with me. These women placed trust and faith in me to share their experiences in a safe and meaningful manner, sharing aspects of

their lives that, for some, had been kept hidden from even the closest around them. I was humbled and deeply appreciative of these women for giving me the opportunity to potentially make a difference with their stories. The protection of the rights and wellbeing of these women was paramount in this research and guided this process every step of the way.

Reducing the power imbalance that can be created when the researcher takes the dominant role was essential to this research as well as creating a mutual relationship with participants. This process involved protecting participants from actual or perceived abuses of power, such as breaches of participants' confidentiality. As Gibson (2016) noted, recruitment via agencies or organisations, as well as interviewing in a public place, or one in which the participant was known could be a risky option. This was considered, along with measures to protect participants' confidentiality during the research process. The predominant use of phone interviews was one way to reduce this risk, with participants able to share their stories from a location they deemed safe and private. With regards to recruiting via agencies or organisations, service providers were able to pass on the information about this research, without necessarily being aware of whether a woman chose to participate unless the participant wanted them to know. This also aided in ensuring that participation was voluntary and non-coercive, as service providers had no way of ascertaining who had participated.

The following chapter introduces the study participants, with the subsequent chapters discussing the key themes resulting from the thematic analysis of the data collected.

## **Chapter Four: Introducing the Research Participants**

### **First Interview ‘Alice’**

The first participant interviewed was recruited under the original Opioid Substitution research scope and was an existing contact of mine. She had seen my interest in the topic of women and Opioid Substitution on my Facebook page and approached me via private message expressing her willingness to be a participant and share her story. Alice was 31 years old and identified as a New Zealand European. She had been on MMT for about seven years, having received treatment at three different clinics in the South Island (of New Zealand) during that time. Alice receives daily doses of Methadone, which she attends a pharmacy to take. Alice started on Methadone at a point in her life where she was really struggling. She had just left a relationship in which the other person was a heavy user. She saw a counsellor at drug and alcohol services who referred her to the MMT programme. Her experiences were positive overall, and she had nothing negative to say about the people involved in her treatment. Her issues were with the rules that they had to follow and what this meant for people on the programme. She was also concerned with the way some pharmacists treated people waiting for their dose, and the impact this could have on the aging Methadone-taking population. Whilst the use of Skype made both of us feel more comfortable, I found it difficult to know when Alice had finished speaking and when to ask another question, not having any visual cues. I found myself speaking over her a couple of times, which I felt affected her ability to share her story. Listening back on the interview recording an hour or so later I identified areas of improvement for my interview technique, such as allowing more time for the participant to respond, rather than assuming they had finished.

## **Second Interview ‘Rebecca’**

Rebecca was a 49-year-old who identified as New Zealander or Pākehā (European). Rebecca had received treatment for drugs in the past but identified as actively pursuing recovery at present. Primary health care was Rebecca’s main source of treatment, receiving assistance from a GP as well as attending community alcohol and drug groups, and having a case manager at the alcohol and drug service in her city. Rebecca decided to seek help after hitting ‘rock bottom’ and realising that her drug use was problematic. Her experiences were positive overall, however, mental health issues made her journey harder, especially with co-occurring mental health conditions not acknowledged during her first treatment in the early 2000s. She found that this had improved in 2012, as had treatment facilities seeming more welcoming and not as overworked and underfunded, although she still sees this as an issue. Rebecca found that doctors and nurses were very understanding and helpful, and the treatment providers did what they could. Although she experienced self-stigma, her treatment experience allowed her to meet others, find her voice, and share common experiences. She also found the discussions about the possibility of change very positive and helpful. Rebecca believed that there needed to be more spaces for women which are safe and acknowledge their unique needs. She further believed there needed to be more peer support services and more research into the treatment being provided, especially in a New Zealand context. Rebecca found out about my research through my emails to service providers and was very enthusiastic to take part. As she lived in another part of the country, we decided the best course of action was to do the interview via phone. I found that this interview flowed a bit better than my first with Alice, although, we did still talk over each other on occasion, and I was concerned that the background noise from my neighbours may have caused some distraction. I realised that I still had some improvements to make on my

interview technique, learning the right balance between leaving space and asking the next question. However, Rebecca had plenty to share, with this being the longest interview and one of the most crucial to this research.

### **Third Interview ‘Sarah’**

Sarah was a 45-year-old who identified as New Zealand European. She was currently receiving treatment for alcohol issues and had also received treatment for drug issues. Sarah attends a women-only group, which she speaks highly of. She had tried AA in the past, but felt it was not for her, and mixed-sex groups made her feel uncomfortable and unsafe. She found the women’s group to be comprehensive, with lots of support and a non-judgmental nature. The connections and friendships Sarah had made through this group were beneficial and crucial to her recovery. The self-esteem group was a huge part of Sarah’s story, and she spoke highly of the benefits. Although Sarah had to ease some friends out of her life, many were also very supportive of her seeking treatment. Whilst her experiences with the women’s group were nothing but positive, Sarah had some negative experiences with other groups and professionals, feeling judged and stigmatised whilst in the hospital because of the amount of medication she was taking for an ongoing medical condition and her drinking. She also found that her GP was not much help, with a lack of knowledge on where to refer her, although they were very supportive. Sarah would like to see more information sharing between services, particularly with GPs, on what services and treatment options are available and what they offer. Sarah was recruited via emailing service providers and was very happy to share her experiences. As she lived in another part of the country, this interview took place over the phone. This interview flowed much more smoothly on my part, although we were interrupted by someone needing to speak with Sarah during the interview. Despite this, the interview flowed smoothly, and we

found ourselves talking not only about her own experiences, but discussing drug and alcohol treatment generally, both here and in the United States. We could converse back and forth, generating a good rapport. I found myself congratulating Sarah on her recovery journey, almost brought to tears by her story and the images of her transformation that she created. I became very emotionally invested in this interview, and it has been one that has stuck with me throughout this process. This interview gave me an insight into what it means to be vulnerable and invested in an interview.

#### **Fourth Interview ‘Emily’**

Emily found out about my research through a service provider, being one herself, as well as receiving past treatment for alcohol misuse. Emily was a 51-year-old who identified as New Zealand European. She received treatment for alcohol misuse over ten years ago and was hesitant that this was too long ago. Emily received outpatient treatment and counselling through the regional alcohol and drug service, transitioning to an after-care group. She also attended AA meetings, as well as a three-day a week intensive outpatient treatment programme through this service, which was an all-women group. Emily’s experiences were resoundingly positive, with her friends and family also very supportive. Her counsellor at the regional service was caring and supportive, as were the facilitators of the programme. These facilitators challenged her and her attitudes, which she found helpful. This interview was once again conducted via phone due to distance reasons, and due to time constraints, as Emily was going away shortly after we spoke. This interview flowed smoothly also, even with the addition of a second part of the interview, asking her questions as a service provider (peer-support worker). Emily herself provided the transition into discussing her professional role and experiences in working with women receiving alcohol and drug treatment. Emily had been a peer-support worker for six years, with another



year in social work. Her service has a holistic approach, providing mobile visits, as well as appointments at their service. These mobile visits were particularly helpful for mothers, who experience barriers to attending treatment. Men and women are treated equally at this service, with a focus on their goals, and offering practical support. Emily believed that women often take on a lot more responsibility than men, especially with childcare, as well as experiencing more stigma than men do. More treatment options to reduce wait times and more services that are mobile were improvements that Emily would like to see in funding. Emily provided a unique perspective, sharing both sides of her story. This interview was a good lesson for me in the interconnectedness of the treatment community, with many who have experienced drug and alcohol treatment often going on to work in that field.

#### **Fifth Interview ‘Nicky’**

Nicky was a 69-year-old who identified as Caucasian. She was currently on the Methadone programme and had been for almost 20 years. Nicky started treatment as she wanted to get off the drugs and get her life back. She did not want anything to have power over her life. Her experiences were positive overall, although she would have liked more support and guidance when she did come off Methadone at one point, and she would also have liked more support and knowledge from her GP. She also felt that medical professionals did not help her with the side effects she was experiencing, which was quite a negative experience. Nicky did not have much to say about what needed to change about the way treatment was provided to women, but welcomed the additional option of Suboxone as an alternative to Methadone. Self-stigma was experienced by Nicky, feeling embarrassed for having substance issues, although she did not identify this as stigma. Nicky heard about my research through an acquaintance and agreed to take part. Communication with Nicky was difficult because she was hard of hearing, I needed to

repeat questions, and wait longer for replies, which made the phone interview more difficult. This was an interesting test of my interview skills, teaching me the need to adapt my interview style to different types of people. This interview was also challenging as Nicky stuck strictly to the questions asked and did not elaborate. Open-ended questions were answered in a way that made them seem closed. I ended this interview feeling a little bit disappointed, and questioning my interview skills. I was concerned that I had done something to prevent rapport building, or that I had approached something in the wrong way, offending Nicky. This was something I had been wary of for all my interviews, however, as the interview progressed it seemed that it was more Nicky's personality and way of talking. This interview really tested my ability to persevere with the interview despite difficulty creating a dialogue. I initially thought little had been gained from the interview, however, listening back on the recording the next day, I realised that Nicky had shared some interesting points. My frustrations with the interview and concerns about my own ability to conduct the interview had temporarily obscured the aim of this research and these interviews, for women to share their stories, in their own way. Whilst challenging, this interview was a good reorientation tool.

### **Sixth Interview 'Melissa'**

The sixth woman I interviewed was Melissa, a 39-year-old who identified as a 'Kiwi.'<sup>38</sup> Melissa was currently receiving treatment for alcohol issues, having been through the justice system. Melissa attends an all-women group through an organisation, AA meetings, as well as additional counselling for other personal concerns. Melissa had also attended a couple of groups whilst in prison, transferring to a halfway house upon release. She had been attending the group

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<sup>38</sup> This is a colloquial term for someone who identifies as a New Zealander.

for about a year and a half and had been attending AA for a number of years. It was being in the halfway house that set her up to continue her treatment and introduced her to the women-only group. Conducted via phone, this interview ran smoothly, reinstating my confidence in conducting these interviews via phone. There were no interruptions, and we seemed to build a good rapport. As with the other women interviewed, Melissa's overall experiences were very positive, particularly with the women's group, the facilitators, and the other women there. She found the group to be very supportive and safe, with the self-esteem group of particular importance to her. Like many of the women, Melissa had to cut ties with several of her previous friends, but her parents were very supportive, as were the few close friends she did keep. Melissa would like to see more information and communication about the treatments that are available, as, if it was not for the halfway house, she would never have known about the women's group. This includes more information for GPs about where they can refer patients. She would also like to see more education in schools.

### **Seventh Interview 'Group Interview'**

The seventh interview conducted was a group interview with five women from a treatment facility. This was my first face-to-face interview, which was very daunting, especially because I was interviewing these women at the treatment facility, entering their safe environment. The clinical manager invited me to the facility, with the permission of the women, having contacted me regarding my email about the research. I spent two hours on a bus to get to the facility and spent the rest of the morning sitting in on part of their mixed-group session before interviewing the women during their lunch break. I was invited to take part in the activities, which, whilst daunting at first, proved fun, and made me feel more comfortable, and, I hope, made the women feel more comfortable too. Going into the facility and the interview I

was concerned about encroaching on the women's space and making them feel awkward or 'watched' in what would be considered a safe space. However, as soon as I walked in the door I was made to feel welcome and was included in their group. I felt far more comfortable. Rather than me trying to make these women comfortable, it ended up being the other way around, which highlighted the reciprocal nature of the interview process. One woman even offered to return the grocery voucher given in thanks so that I could get some lunch, which I had been unable to do at that point. I politely refused but felt very welcome and considered. Technology, unfortunately, hindered the write up of a transcript of this interview, as my recorder wiped the content. I wrote an interview summary from memory as best I could, however, was unable to recall verbatim what was said and by whom. Collectively, these women were all currently receiving residential treatment at the facility through a nine-week programme, which included group work, as well as community building and practical skills. The women were all at different stages in the programme and ranged in age from 27 to in their 50s. I did not seek to find definitive ages for some of these women, as it was not crucial to this research, and I sensed that some felt more comfortable giving an approximate age. The identifying ethnicity of these women also varied, with most identifying as New Zealand European, with at least one identifying as Māori. Most of these women had also received treatment previously from other providers including NA, AA, community programmes and the current treatment facility. Amongst these women, there was a mix of family and friend support for their treatment seeking. Some had a very supportive family, who were looking after their children, whilst others did not have much to do with their family. Many of these women also had to cut ties with friends and family upon entering treatment. These women had overall positive experiences with the treatment facility, particularly the caring and support from the staff, and their non-judgmental nature. The practical support and advocacy

they receive were also really important. Experiences of stigma were also varied. No stigma was experienced at the treatment facility, but some women had experienced stigma from other healthcare providers. To help the women feel at ease they were provided with the interview schedule a week or so before I came to visit, with the questions surrounding stigma generating confusion and questions. Some women did not understand what I meant by stigma, something that I did not expect. This made me reconsider the ways in which my questions were worded and considered. It made me question whether, by using such terminology, I was placing myself on a pedestal. From this point, I learned the need to better explain my questions, and the need to reword things for different groups.

One of the main things these women thought needed to change was the need for more marketing and promotion about what treatment options are available, a theme which emerged in many interviews. These women also highlighted the importance of treatment providers not being too soft and over-sympathetic. Actually caring and supporting them was important, but not pandering to them.

The group interview format posed a few issues. Some of the women had their one-on-one counselling appointments during this time, so they went in and out of the interview, not answering all questions, with another having to leave early. This was a bit disruptive to the process, and I was concerned about what this would mean for the ability to use these interviews. I also observed that some of the women played on their phones whilst others were talking, or played with things on the table, obviously bored. I was concerned about keeping them engaged, but also aware that I wanted to keep the environment as unobtrusive as possible. Two of the women also dominated the discussions, with the others much quieter, needing to be prompted to share their stories and views. This experience highlighted the difficulties of conducting group

interviews. One-on-one interviews are better for engaging participants and making them feel that their voices are heard, but these women also preferred to be interviewed as a group. Despite the challenges to this interview, these women had a lot to share.

One woman asked for a follow-up interview via phone to discuss her difficulties with family court. Her experiences did not have anything to do with her substance use, but I could tell that she needed someone to talk to. We agreed to a later time for the interview. I was unsure of how to go about this interview, as I had no specific guiding questions for an area outside of my topic of study. I asked her to simply tell me her story, letting her know that I was not sure what I could do with the information. She was grateful for someone to talk with, and thanked me for my time, even though I was unable to do anything with this part of her story.

### **Eighth Interview ‘Amanda’**

Amanda was a service provider who responded to my email about this research. Having traveled to speak with some of the women at her residential facility, she also agreed to a face-to-face interview to discuss her role and her perspectives on women’s drug and alcohol treatment. Amanda had fifteen years’ experience as a professional in the drug and alcohol treatment field, both in New Zealand and overseas. Amanda believed that women experienced many differences to men in treatment, especially in their role as a mother in many cases, with women less likely to self-refer themselves to treatment. She believed they experienced more judgement and stigmatization about their drug and alcohol use, as well as their treatment seeking. Her service provided a safe, supportive and caring environment for these women, focusing on other aspects of their lives, not just drug and alcohol use. However, Amanda would like to be able to house children with their mothers at the service, having the children involved in the women’s recovery and helping to facilitate crucial bonding. Amanda saw a need for a change in policy and funding

to focus more on children aged under five who have mothers with alcohol and drug issues or are in treatment. Amanda also believed there needs to be more education in schools about what help is available. She encourages policymakers to get out of their ivory towers and speak with women and make policies with them, not for them.

I was quite nervous doing this interview, as I was aware that Amanda was very busy, and I did not want to be seen as wasting her time. I was also aware of my own fear of appearing unknowledgeable on the topic of women and drug and alcohol issues, concerned that I may ask or say the wrong thing. Lacking life and practical experience, I felt intimidated by Amanda, despite her making me feel welcome at the treatment facility. Despite this, I do not feel that my apprehensions impacted the interview, with Amanda's open and straight-to-the-point personality helping the interview flow nicely. Parts of the interview were interrupted with other workers coming into her office to ask questions, which did affect the flow of the interview, and made me a bit unsteady in my asking of questions and responses. I felt at this point that I was relying too heavily on my interview schedule structure, rather than allowing for further questions and expansion on topics raised. We were also pressed for time with this interview, as I needed to catch the bus back to Wellington. Our interview had been pushed back, with Amanda having her day-to-day work to do, and so, I was also a bit worried about the time factor. Despite this, Amanda had so much knowledge to share, and I felt privileged to have part of her time for this discussion. Unfortunately, the recorder also wiped this interview, so I was unable to transcribe verbatim. As per the group interview, I wrote an interview summary as best I could from memory, capturing the majority of the content.

### **Ninth Interview ‘Hannah’**

Hannah heard about my research via my emails to treatment providers and emailed me to set up an interview time. We conducted the interview via phone, as she was in another part of the country. Hannah was a 39-year-old who identified as New Zealand European. Hannah had previously attended treatment for drug and alcohol use, attending both residential and community-based treatment, she also still currently attends AA meetings, with most of her treatment being 12-step based. Hannah started treatment when she realised that she could not give up substance use on her own. She had started using drugs to replace her drinking, realising that she was replacing one problem behaviour with another. Family and friends were supportive of Hannah entering treatment, with family attending family therapy, and friends visiting her while she was in residential treatment. Overall, Hannah’s experience was positive, and she found the residential living tough, but very beneficial. She learned to live in a community, and felt part of this community, learning life skills. Hannah’s experiences with her GP were less positive, having approached them for help with her drinking, and simply being prescribed a drug. Hannah did not understand why they would prescribe an addictive substance to someone struggling with substance issues. Hannah would like to see more access to treatment, as well as more treatment for women. She would thank treatment providers for saving her life and giving her a life she never thought possible, whilst encouraging them to keep it fair and tough, teaching people to be accountable.

This interview went smoothly, and I did not encounter any major issues. The conversation flowed nicely, and there were no interruptions. Hannah and I seemed to develop a good rapport, and she wished me luck with the research.



The following chapters discuss the results and themes of this research, beginning with the participants' experiences of stigma.

## Chapter Five: Stigma

Stigma is pervasive for many PWUD, and to some extent, those who use alcohol problematically, impacting their lives in multiple ways. This is particularly the case for WUUD and alcohol (Ridlon, 1988; Stringer, 2012). These women are seen as doubly deviant, breaking societal gender and legal norms as both a substance user and a woman who uses substances (Gibson, 2016; Levy, 2014). Stigma can be worse for women who are problematic substance users, and particularly for mothers, as substance use does not fit with socially constructed gender role expectations (Cohen, 2000; Schur, 1984). The archetypical mother is not one who uses substances and perceivably puts her child at risk (Gibson, 2016; Schur, 1984). Research on substance-using mothers tends to focus on the impact that their substance use has on the health and wellbeing of their child and family (Gibson, 2016; Poole & Dell, 2005), rather than how women can navigate treatment and childcare. As discussed above, motherhood can be both a motivator for treatment and a hindrance due to fear of losing their child and stigma from professionals (Gibson, 2016; Greenfield, 2002, Levy, 2014), with the media creating a bifurcated ‘good’ non-substance-using mother and ‘bad’ substance-using mother (Australian Injecting and Illicit Drug Users League (AIVL), 2011; Gibson, 2016). Substance-using women are considered a risk to their current and future families, society and themselves, portrayed as ‘unfit’ mothers (Boyd, 2006, Gibson, 2016). Birth complications are often blamed on maternal substance use, despite evidence indicating that social, economic and other variables impact on the health of an infant and mother (Boyd, 2006; Gibson, 2016). Nonetheless, mothers are often stigmatised further for ‘endangering’ their child (Carter, 2002; Malinowska-Sempruch & Rychkova, 2015; Smith, 2006), with some areas of the United States prosecuting women for drug use while pregnant. During the late 1970s-1980s prosecution of drug-using, pregnant women emerged in

the United States. Women who deliver drug-exposed infants have been charged with various crimes including criminal neglect, child endangerment, and abuse, delivering drugs to a minor, involuntary manslaughter, homicide and murder (Kampschmidt, 2015; McGinnis, 1990). Prosecuting these women evidences the extent of double-deviancy and the intensiveness of stigma, discussed in Chapter Two, as women are criminalized for their status e.g. being a substance user and being pregnant (McGinnis, 1990). Feminist theory facilitates the exploration and unmasking of these issues, examining how systems of power and oppression interact to disproportionately impact certain populations, particularly poor, minority women (Carastathis, 2014). The criminalisation of pregnant drug-using women distracts from significant social problems, including the lack of universal healthcare in the United States, the dearth of policies to support pregnant and parenting women, the lack of social supports for children, and the ultimate failure of the drug war (Flavin & Paltrow, 2010). These attempts to protect the fetus via the criminal justice system undermine maternal and fetal health and discourage the identification and implementation of effective strategies to address the needs of pregnant drug users and their families (Flavin & Paltrow, 2010). The criminalization of pregnant substance-using women exemplifies one form of stigma experienced by substance-using women. The following section describes what stigma is, and how it can impact treatment seeking.

Stigma occurs when a person possesses an attribute or status that makes them less desirable or acceptable in the eyes of others, impacting their interactions (Lloyd, 2010). Research suggests that stigma exists because of a power imbalance between the stigmatised and the stigmatiser and stems from the normal way in which people make sense of the world and its complexity (Jones et al., 1984; Link & Phelan, 2001; Lloyd, 2010). Stigma can be a barrier to recovery and rehabilitation (Gibson, 2016; Lloyd, 2010; Stringer, 2012), with stigma existing on

different levels, self, social and structural, acting as a harm to substance users (Gibson, 2016; Lloyd, 2010). Blame is at the heart of stigmatisation, with those deemed responsible for their actions or predicament treated more harshly (Lloyd, 2010). Problematic drug use has been described as a Master Status, whereby stigma obscures all other aspects of the person's identity, they are seen only as a substance user (Goffman, 1963; Lloyd, 2010; Schur, 1984). This chapter will discuss the various levels of stigma as it impacted the women in this study, highlighting that stigma was crucial to the themes of this thesis, and the experiences of women in treatment. The voices of these women are important, explaining their first-hand experiences of stigma as women seeking treatment, and how this impacted their treatment experience. This chapter will first explore the literature surrounding stigma and how one comes to be stigmatised, examining the ways in which the women described themselves and the way others treated them. This will be done alongside a discussion of Goffman's (1963) concept of the Master Status. The chapter will then go on to discuss the impacts of stigma on women and their treatment experiences, particularly self-stigma. A discussion will also be provided focusing on the different levels of social and structural stigma experienced by the women in the current study. Service providers' knowledge of the existence of stigma for women with SUDs will also be examined. The chapter will end with a discussion of the differences in stigma experienced by those women on Methadone compared to women receiving other forms of treatment.

### **The 'Master' Status**

Goffman (1963) proposed that stigma can become the attribute most focused on, overshadowing the individual's identity, becoming a Master Status (Lloyd, 2010; Schur, 1984). Problematic drug use is considered a Master Status, with the individual's thoughts, actions, and lifestyle attributed to their drug use (Gibson, 2016; Lloyd, 2010). However, there is little

research on problematic drinking as a Master Status, although those with alcohol dependence are one of the most stigmatised groups (Schomerus et al., 2011). Treatment may also help cement one's substance user Master Status, necessitating acknowledgement of having a problem (Lloyd, 2010). Such confirmation of the Master Status demonstrates that entering treatment is a double-edged sword: to receive treatment, one must accept a stigmatised position, which can be extremely confronting. This Master Status can be more prominent for WWUD because of societal gender stereotypes and expectations (Carter, 2002; Gibson, 2016; Schur, 1984). Women are expected to be moral and rational (Cohen, 2000; Ridlon, 1988), restrained and quiet, and substance use does not support these expectations. Ettorre (2007) also discusses how substance use is considered a pollutant of the female body, further deviating from the clean and pure expectation, additionally drawing attention to the notion of appropriate femininities and feminist theory's attempts to challenge these notions. This Master Status can impact on a problematic substance user's relationship with service providers such as doctors, nurses, pharmacists, case managers, and the public, which can influence their experiences of accessing and attending treatment. These interactions can be worsened by the negative attitudes of others and the treatment they receive (Gibson, 2016).

### **Self-Stigma**

Those with SUDs are frequently aware of the negative perceptions and stereotypes others hold about them (Gibson, 2016). As their substance use progresses they often begin to internalise these negative perceptions (Schomerus et al., 2011). Research in the field of mental illness indicates that self-stigma is associated with depressive symptoms, low self-esteem and low self-efficacy (Schomerus et al., 2011). Research also suggests that self-stigma can hinder help-seeking in those with mental illness (Schomerus, 2009; as cited in Schomerus et al., 2011).

Corrigan, Watson, and Barr (2006) proposed that self-stigma occurred in a four-stage process. First, the individual becomes aware of the negative stereotypes endorsed by others. Secondly, they personally agree with these stereotypes before they then apply these stereotypes to themselves. Finally, the individual experiences low self-esteem due to the application of these stereotypes (Corrigan et al., 2006; Schomerus et al., 2011). Some of the women in this study spoke of themselves in ways that were reminiscent of stigmatised labelling.

*“I’m an alchie. I’ve done lots of drugs, but I wouldn’t consider myself a drug addict.”* – Melissa (39, alcohol treatment, interviewed via phone).

Melissa said this without hesitation and emotion, with the use of this language highlighting the extent of the internalization of negative connotations of the self and stigma for substance-using women. Literature frequently discusses the negative consequences of labelling (Glass, Mowbray, Link, Kristjansson, & Bucholz, 2013; Link, 1987; Shoemaker, 2005; Traub & Little, 1999), and to hear some of these women refer to themselves in such a negative manner was surprising. However, it did reflect their own self-awareness and an ownership of their situation and behaviour, as well as the internalisation of stigmatised labels.

Nicky also discussed why she kept her drug use and treatment seeking secret from her friends and family. The terminology she uses to describe herself (drug addict) is like that of Melissa.

*“Because it’s embarrassing being a drug addict.”* – Nicky (69, Methadone, interviewed via phone).

Nicky’s avoidance of having her drug use and treatment seeking known is reflective of Goffman’s (1963) concept of the Spoilt Identity (Gibson, 2016; Lloyd, 2010). This Spoilt Identity impacts how the stigmatised individual interacts with others (Gibson, 2016). Goffman

(1963) notes that stigma occurs in stages and across a continuum, once the Master Status is revealed and the spoilt identity realised, stigmatised individuals are not as afraid of the status being applied to them (Gibson, 2016; Jones et al., 1984). Hannah alluded to this when she was discussing her first AA meeting.

*“I guess I felt shame at my first meeting. I was scared, and I didn’t know what it was all about, but by the end that was over. By telling people I had a problem I accepted it myself, whereas, having it as a secret and being fearful of the stigma, I couldn’t accept myself because I was completely ashamed of myself and what I was doing.”* – Hannah (39, alcohol and drug treatment, interviewed via phone).

Hannah’s shame in her behaviour is like that experienced by individuals in McIntosh and McKeganey’s (2001) study, who were recovering from dependent drug use. Their thoughts were expressed in various ways including unhappiness at the kind of person they perceived they had become, a dislike of the activities they were involved in, or a dislike of the drug world and drug users (McIntosh & McKeganey, 2001; Gibson, 2016). Before she accepted that she had a problem Hannah exhibited a shame and unhappiness in herself for the person she had become. Entering treatment appeared to have a positive influence on Hannah facing her stigmatized identity, and consequently overcoming it.

Rebecca also mentioned the added stigma involved with comorbid mental health conditions when discussing seeking help for her anxiety alongside her substance use. Rebecca experienced a lack of acknowledgement of her anxiety and the impact it had on her substance use, as well as her life generally.

*“It (Anxiety) created some self-stigma. That I might not have been worthy (of treatment and life), or that I was bad or slightly mad, crazy.”* – Rebecca (49, drug treatment, interviewed via phone).

Women in substance use treatment are more likely to experience comorbid mental health conditions (UNODC, 2004), which can be highly stigmatised in themselves. Stigma is pervasive and multi-faceted in substance-using women’s lives; therefore, treatment needs to address this to help women overcome stigma. Women who use substances can face triple stigmatisation as women, as substance users, and as someone with mental health problems. Combining that with substance use and seeking substance use treatment can create an even more stigmatised environment.

### **Social Stigma**

The attitudes of the public towards problematic substance users are often based on negative stereotypes, rather than evidence and personal experience (Gibson, 2016). Surveys by the Royal College of Psychiatrists in 1998 and 2003 found that between 60% to 78% of respondents agreed that those addicted to drugs were dangerous to others, unpredictable and hard to talk with. They also agreed that they only had themselves to blame (Crisp, Gelder, Goddard & Meltzer, 2005; Lloyd, 2010). However, less than half thought that problematic substance users feel different from the way we feel at times, could pull themselves together if they wanted, would not improve if given treatment, or would never fully recover (Crisp et al., 2005; Lloyd, 2010). Those addicted to drugs were more stigmatised than those suffering from mental illness, or those with alcoholism, suggesting that alcoholism was viewed more favourably than illicit drug addiction (Crisp et al., 2005; Lloyd, 2010). This greater positivity towards alcoholism reflects the bifurcation of drugs into legal and illegal categories, as good, or at least acceptable,



and bad, irrelevant of their harm potential (Nutt et al., 2007). An awareness of this on the part of PDUs leaves them attempting to hide their drug use to avoid stigmatisation (Gibson, 2016).

However, there is little literature surrounding whether those in treatment also try to hide their treatment attendance to appear ‘normal.’ Stigma theorists discuss the ability to ‘pass as normal,’ whereby stigmatised individuals can keep their Master Status hidden from others through the process of ‘image management’ (AIVL, 2011; Gibson, 2016). This enables them to avoid stigmatisation and appear like any other member of society. Rebecca discussed how she had to hide her treatment for fear of judgement, and the repercussions for her daughter.

*“There’s a whole heap of negative connotations loaded with going through drug and alcohol treatment. It’s not something you tell the school teacher or the principal of your daughter’s school. It’s not something you disclose to her.”* – Rebecca (49, drug treatment, interviewed via phone).

Rebecca’s concerns about the reaction of her daughter’s teachers exemplifies the need to ‘pass’ and manage one’s image to avoid social repercussions. It also highlights the impact that the stigma attached to those using substances or seeking treatment can have on those closest to them. Rebecca’s experience could also be considered an example of perceived stigma.

Perceived stigma refers to the beliefs the stigmatised group has about the prevalence of stigmatising attitudes in society (Luoma et al., 2007). Rebecca assumed that the principal and school teachers would look down on her for being in treatment because of the stigma surrounding substance use and treatment. This perceived stigma impacted Rebecca’s ability to interact with these figures who were crucial in her daughter’s schooling, reflecting the impact that the Master Status and spoilt identity can have on relationships, and family members (Corrigan, Watson & Miller, 2006). Buchanan and Young (2000) found that drug users felt

rejected and stigmatised in the presence of non-drug users or anxious around ‘normal’ people. These feelings could result in them avoiding contact with non-drug users, impacting their access to positive influences and relationships (Buchanan & Young, 2000; Lloyd, 2010).

A lack of public knowledge surrounding drug and alcohol treatment also perpetuates stigma. Residential treatment and AA meetings are the treatments most often depicted in popular media (Streckfuss, 2015), informing the public’s opinions and knowledge about substance use treatment. These notions of treatment, therefore, fail to acknowledge the different types of treatments available. Negative perceptions of Methadone treatment and what it entails also significantly impacts on the lives of those on Methadone, or considering entering a Methadone programme (Liu et al., 2013; Pearson, 2015; Woo et al., 2017). Alice spoke of this when asked about her experiences of stigma whilst on the programme.

*“People think it’s just a huge, you know, one addiction for another. It’s not. There’s no euphoria involved with Methadone. It doesn’t alter your state at all, other than making things a lot more stable... and most people don’t know that, they think it’s just another drug. It’s a bit frustrating.”* – Alice (31, Methadone, interviewed via Skype).

MMT has been significantly criticised in the literature as simply replacing one drug for another (Caplehorn, Lumley, Irwig, & Saunders, 1998), suggesting that professionals in the field also held stigmatised views of Methadone programmes. Such views can have a profound impact on Methadone clients. As Alice mentioned, she became frustrated with the lack of knowledge held by many about how Methadone works and what it is for, a lack of knowledge which perpetuated the stigma surrounding being a Methadone client.

Problematic substance users and those seeking treatment can also express stigma towards members of their own group (Furst, Johnson, Dunlap & Curtis, 1999; Gunn & Canada, 2015;

Radcliffe & Stevens, 2008). Many of those in Radcliffe and Stevens (2008) study viewed drug treatment services as being for ‘junkies,’ with participants working to distance themselves from that status, a form of ‘positioned othering’ (Hutton et al., 2016). Alice discussed stigma towards Methadone clients when describing her thoughts on starting Methadone treatment.

*“My only experience with Methadone was... just really stereotypical people that you see that have been on it for years and they’re missing their teeth and they’re skinny. I was worried I would get on and stay on for the rest of my life.”* – Alice (31, Methadone, interviewed via Skype).

The stigmatised views Alice held of others on Methadone impacted her decision to enter the Methadone programme, her thoughts on others in the programme and what she would become if she also entered the programme. This exemplifies the interrelation of self, social and structural stigma (to be discussed in the next section). The different levels of stigma affect each other and are often present together. Alice’s experience also highlights how stigma can impact treatment entry (Anstice et al., 2009; Woo et al., 2017). A fear of becoming a ‘lifer’ is also common for some of those on Methadone (Vigilant, 2001), concerned that they will never be able to come off Methadone, or what life will be like if they do.

### **Structural Stigma**

The public view problematic substance users (particularly illicit PDUs) as deceitful, dangerous, unpredictable, unreliable and to blame for their situation, with some health professionals distrustful and judgmental towards PDUs (Lloyd, 2010). The attitudes of staff are based not only on their experiences of working with PDUs, but are also influenced by societal attitudes, as members of the community (Lloyd, 2010). Regrettably, stigma and discrimination are still faced by women with problematic substance use and those entering treatment by

healthcare professionals. AIVL (2011) discussed how some healthcare workers admitted stigmatising clients with the mistaken belief that these attitudes could discourage problematic drug use. McLaughlin and Long (1996; as cited in Lloyd, 2010) concluded that many health professionals held negative, stereotypical perceptions of illicit drug users in their review of studies from the 1980s and 1990s. It is argued that the stigma from healthcare professionals is the most damaging to those with problematic use (AIVL, 2011; Gibson, 2016), especially given that PDUs also experience the same, if not a higher level of illness as the general population and must interact more frequently with healthcare professionals. Their interactions are often negative due to healthcare professionals' assumptions that the individual is drug-seeking (AIVL, 2011; Gibson, 2016). This can result in individuals being denied medical care and medication that they need, and have the right to receive (AIVL, 2016; Gibson, 2016). This assumption surrounding drug-seeking is not just an overseas occurrence, with a Radio New Zealand article describing the experiences of a terminally ill cancer patient from Nelson, New Zealand whose request for an increase in his pain medication dose to help him cope with pain was denied by the addictions service. The service believed he was drug seeking, because of his history of problematic drug use, and unlikely to be in the amount of pain that he claimed (Brown, 2017). A miscommunication between hospital staff and the addictions service regarding his prognosis resulted in no increase in medication and left him in incredible pain (Brown, 2017). This highlights the potential negative consequences of structural stigma and the very real harm it can cause. Sarah experienced these negative drug-seeking assumptions whilst in the hospital for an issue unrelated to her drug use.

*“When I was in hospital when I got sick, I was there for a couple of weeks. There was a lot of judgment passed at the hospital. At the time I was on Oxycontin because I suffer*

*from chronic pain, and so, when I got sick they took me off that. So, all of a sudden, I have this drug addict label on me, and I was taking it for pain relief. The way I was treated there wasn't very fair or nice.*" – Sarah (45, alcohol treatment, interviewed via phone).

Sarah's physical wellbeing was put in jeopardy because of the stereotypical and misinformed beliefs held by medical professionals. She was left feeling hurt and distrustful of medical staff. Another participant also experienced stigma in the hospital setting. One of the women in the group interview described how she was at the hospital with her partner and child because their child was unwell. The participant explained that she believed that because of the way the staff perceived her and her partner to 'look,' (like someone who used drugs) hospital staff assumed that their child had been abused and Child, Youth and Family services were called. Investigations later proved no abuse occurred, but no apology was given. This experience left the participant feeling angry and distrusted.

Pharmacists are referred to as a unique source of stigma for problematic substance users and Methadone clients in particular. Research suggests that pharmacists can hold highly stigmatised views of problematic substance users, concerned that they may steal, as well as concerns regarding the reactions of 'normal' pharmacy goers (AVIL, 2011; Gibson, 2016). For Methadone clients, the pharmacy presents an open environment for the stigma to occur. Many clients are required to attend a pharmacy for daily doses, waiting in line for their turn. This leaves Methadone clients extremely visible and open to public stigma. Pharmacists may also look down on Methadone clients for the reasons mentioned above, as well as their own personal views. Matheson (1998) interviewed 124 problem drug users from 23 pharmacies in Scotland, with over half of the sample happy with how they were treated at the pharmacy. However, a

substantial number did report negative experiences, with some feeling looked down on, spoken to sharply or looked at suspiciously (Lloyd, 2010; Matheson, 1998). This left the individuals feeling shamed. Sheridan, Wheeler, and Walters (2005) reported that pharmacists can focus on the Master Status, which can lead to general health problems, like those experienced by the general population, being associated with drug use (Gibson, 2016; Sheridan et al., 2005). This can have significant health impacts when pharmacists treat Methadone clients requesting cold medicine with suspicion or assume they are drug seeking (Gibson, 2016; Sheridan et al., 2005). Alice experienced stigma at the first pharmacy she attended. Her experience with service providers had been positive except for this pharmacy.

*“...Mostly positive from pharmacists and things, there’s only one real negative that I can think of and that’s... I changed pharmacies about a year ago because the last one I was going to was not very welcoming to Methadone clients at all. You’d go in for your dose, and even if there was nobody in the whole pharmacy you were left waiting between twenty and forty-five minutes before they would serve you. They would sit and finish their conversation about what they got up to in the weekend before they would even acknowledge your existence.”* – Alice (31, Methadone, interviewed via Skype).

Alice’s experience speaks of pharmacy staff with highly discriminatory attitudes which impact on a client’s ability to live a productive life. The aim of Methadone is to stabilise a client, taking away their drug cravings to enable them to live relatively normally, to work and have a family. Such stigmatising and discriminatory attitudes as those expressed by the pharmacy staff interfere with this ability and intensify self-stigma.

Despite these negative experiences, most of the women in this study did not experience as much social and structural stigma as I expected. Literature suggested that stigma was

prevalent for problematic substance users (Earnshaw et al., 2013; Leshner, 1997; Lloyd, 2010), however, most spoke highly of their interactions with professionals, friends, and family. Relationships are discussed in more detail in Chapter Six. What became apparent was that these women experienced self-stigma where they did not think they experienced stigma at all. Nicky, for example, said she did not experience stigma, but then mentioned that she did not tell her friends and family about entering treatment because it was ‘embarrassing to be a drug addict.’ It may be that this thesis attracted those who had had positive experiences overall, or it may be that their treatment providers were a select group of relatively non-stigmatising individuals. Those service providers interviewed (one of which provided treatment to other women interviewed) were aware of the stigma faced by women in substance use treatment, suggesting that at least some professionals acknowledge the differences experienced by women in treatment compared to men.

*“I suppose there is a bit more stigma around women. Especially mothers.”* – Emily (51, substance use treatment provider, interviewed via phone).

Surprisingly, most women in this study did not identify gendered stigma and experiences in their treatment. When asked about how they thought their treatment differed to that of men if at all, most respondents were unsure or unable to answer. They did not really consider the differences that women may experience.

*“I never identified as a woman. I never really hung out with women when using and... That concept of being a woman...”* – Hannah (39, alcohol treatment, interviewed via phone).

*“I haven’t really had any experience as a male on the programme, so I can’t really say.”*  
-Alice (31, Methadone, interviewed via phone).

In summary, these women did not experience the level of stigma expected based on previous literature. Shame and self-stigma were most prevalent, with some women experiencing structural and social stigma from service providers. Alice's discussion of her pharmacy experience highlights the unique position of those on Methadone. Attending the pharmacy daily can make their status as a PDU public (Lloyd, 2010), and their additional interactions with pharmacists can provide added stigma. Overall, most of these women had non-stigmatising experiences with the public and treatment providers, however, the experiences of those who did encounter stigma suggest that more education is needed for both the wider public and treatment professionals on problematic substance use and its treatment. Further training of some treatment professionals may also be beneficial.



## **Chapter Six: Connections, Relationships, and Knowledge**

Social relationships and connection are central in the lives of most women (Miller, 1976), playing a crucial role in the treatment of problematic substance use (Covington, 2002; Broome, Knight, Knight, Hiller, & Simpson, 1997; Kelly et al., 2010; Vaillant, 2005). In research regarding gender differences and women, Miller (1976) developed the relational model which asserts that the primary motivation for women throughout life is to establish a strong sense of connection. This assertion implies that men do not seek this connection, or that connections do not have the same importance for men. However, humans are inherently social beings, to assume that men do not benefit from connection is to suggest that connections, and their benefits, are a gendered phenomenon. Rather, it may be that men seek connections in different ways than women (Baumeister & Sommer, 1997). Mutual, empathetic, empowering and creative relationships and connections help to create a strong sense of self and self-worth, with healthy relationships creating increased vitality, empowerment, self-knowledge, self-worth, and a desire for further connection (Covington, 2002; Miller, 1976). Healthy connections are crucial for women to ensure psychological wellbeing, and so clinicians working with women in treatment must provide environments for women to form mutual, empathetic and healthy relationships with both counsellors and other women (Covington, 2002). Therefore, because of the importance of connections for women, particularly women in 'recovery', the first part of this chapter examines the importance of connections and relationships to the women interviewed. The second part examines the theme of knowledge, or the lack thereof, particularly regarding professionals' knowledge of treating addictions. These themes are combined in this chapter because of the pathways between connections and relationships and the knowledge these relationships can provide. The theme of connections and relationships is crucial to this thesis because it

intersected every aspect of the women's treatment experiences. This chapter will begin with a discussion of the role that family and peers can play in substance use and treatment, examining the women's experiences of these relationships and the impact they had on them in their treatment journey. The impact of cutting ties with former friends and acquaintances will be discussed, along with the role (or lack thereof) of family in the women's experiences of treatment. The discussion will then move to the impact of beneficial relationships made with treatment providers and other women in recovery, along with a discussion of the ability to be reconnected to life that treatment gave the women. This section will end with an examination of the differences experienced by those on Methadone.

The second section of this chapter will examine the theme of knowledge. This theme also intersected the treatment experience, particularly regarding women's lack of knowledge of their treatment options, and the lack of knowledge of professionals in treating problematic substance use. A discussion will also be presented about the knowledge held by those treatment professionals interviewed about women's needs in treatment. Knowledge or the lack thereof was central to women's treatment experiences because it impacted their ability to enter treatment and receive the treatment they needed, a central aspect of the treatment experience.

### **The Role of Friends, Family and Significant Others**

Friends and significant others can play an important role in both an individual's substance use and their recovery (Brown, O'Grady, Battjes, & Katz, 2004; Gruber & Fleetwood, 2004; Kelly et al., 2010), yet substance use treatments have been criticised for heavily focusing on the individual at the detriment of examining the environmental factors that may foster substance use (Kelly et al., 2010). Research suggests that a crucial aspect of treatment involves strengthening an individual's place as a productive member of the community (Kelly et al.,

2010). Strong, positive and supportive relationships can positively impact treatment success, with those who have a cohesive and supportive family relationship at treatment entry reporting fewer family, drug and psychological problems three months into treatment (Broome, Simpson, & Joe, 2002; Kelly et al., 2010; Reisler, 2012). Family support can also influence motivation to change (Battjes, Onken & Delany, 1999; Brown et al., 2004) and is related to positive treatment outcomes (Kelly et al., 2010; Strauss & Falkin, 2001). Social support in treatment can mean a variety of things for different people and has not been conceptually well defined in substance use research (Lewandowski & Hill, 2009; Reisler, 2012). Social support can be in the form of affective (emotional support), instrumental (practical support) and informational support, for example (Reisler, 2012). The most frequently cited forms of social support are from partners and parents or siblings, with friends also cited (Lewandowski & Hill, 2009). However, for many PWUD, particularly WWUD, family and spousal support is not an option. Family members and spouses can be a factor in an individual's substance use, especially for those who have been abused by family members or spouses or whose family or spouse also use substances (Velleman, Templeton, & Copello, 2005).

Many women in the current study received emotional support from family, friends, treatment providers and other women they met through treatment. As demonstrated in the quote below, Sarah described the importance of simply meeting up with friends for coffee, evidencing that support comes in many forms. Support from others does not mean they must also actively engage in treatment.

*“Their friendship, being there if I was having a bad day, or just a text away. Gone out and had coffees with people, just filling in my time. Because I isolated (myself), because*

*I suffer from mental illness as well, so it was part of getting back out in the community and reconnecting with people.” – Sarah (45, alcohol treatment, interviewed via phone).*

Sarah highlighted the importance of being able to reconnect with the community and people outside of treatment, with the support of her friends helping her to reintegrate back into the community. Reintegration, or integration for that matter, is important for those who are attending or have attended treatment (Lutman, Lynch, & Monk-Turner, 2015; Maluleke, 2013; VanDeMark, 2007; Williams, 2012) because substance use can lead to individuals being isolated and excluded from meaningful connections (Cole & Walker, 2011; Johnson, Pagano, Lee & Post, 2018). Providing these individuals with opportunities to make meaningful, non-substance using connections, and the opportunity to gain meaningful employment, housing and education can reduce relapse potential (VanDeMark, 2007). However, some individuals may not want to reintegrate back into a society that rejected them and therefore the question arises as to whether it is possible for stigmatised substance users to truly reintegrate into their communities. Whilst many of the women in the current study believe they were able to reintegrate, it is important to acknowledge that for many women this is not an option.

Sarah also highlights the added need for support in those who suffer from co-occurring mental health issues, which can leave them further isolated, again evidencing the need for multiple issues (such as mental health and relationships) to be addressed in treatment, not just substance use. Furthermore, the women in the group interview also spoke highly of the practical support provided by staff. They were supported in court, both emotionally and through the provision of progress reports, transport to and from appointments with Work and Income, and with staff providing letters of support for benefit requests. Melissa also discusses the importance of practical support, highlighting the importance of a holistic approach to treatment.

*“The (names treatment provider) have been fantastic... even stuff like helping out with school uniforms, stuff that just takes the pressure off when you’re on a low income.” –*

Melissa (39, alcohol and drug treatment, interviewed via phone).

Emily also discussed practical support from the perspective of a service provider.

*“We spend a lot of money on transport, getting people to different places, GP visits... We bought someone a washing machine the other day, a vacuum cleaner, because they didn’t have all those practical things... Everything affects a person, so it all counts... Like with my own treatment, I’m not a poor person, I’ve got my own car, I’ve got my own resources. So, it was easy for me to do those things (attend treatment). If I didn’t have those things (resources), it would have been impossible. – Emily (51, substance use treatment provider, attended alcohol treatment, interviewed via phone).*

Many women enter treatment with little resources, requiring assistance post-treatment with housing, education, and employment (Sumnall, & Brotherhood, 2012). Life stressors, such as financial strain like in Melissa’s case often contribute to substance use. Thus, ensuring individuals have access to resources to reduce these stressors can reduce the likelihood of relapse post-treatment (Brady & Sonne, 1999; Hanson, 1995; Neupert, Desmarais, Gray, Chon, & Doherty, 2017). The experiences of the women in the current study highlight the importance of supporting women through treatment, both emotionally, and providing practical support to allow them to focus more of their energy on treatment.

### **Relationships with Family**

Relationships with family members were varied for the women in this study. As Hannah refers to below, some women did have family members attend treatment for family counselling, helping them to reconnect. The importance of family therapy for some women is discussed

below. Some of these women also received support from family members to enter treatment whilst others did not even tell family members that they were entering treatment. Not telling family members was linked to stigma for many of these women, as discussed in Chapter Five. When interviewing Nicky, she also confirmed that treatment was something that she did just for her, she did not want or need the input of her family.

*“It (treatment) was just something you did for you?” -Interviewer*

*“Yeah.” - Nicky (69, Methadone, interviewed via phone).*

*“I didn’t actually tell my family. They either know and have said nothing or are just oblivious to it.” – Sarah (45, alcohol treatment, interviewed via phone).*

*“Even people that were still using were really supportive of me going. Some people came and visited while I was in treatment. My mum and her partner came and did family therapy and one-on-one counselling.” – Hannah (39, alcohol treatment, interviewed via phone).*

*“They (family and friends) would drive me to AA meetings at times. Just encourage me to keep going.” – Emily (51, alcohol treatment, interviewed via phone).*

Hannah’s quote highlights the importance of family being involved in therapy for some women. Family therapy has traditionally been used in the treatment of adolescents, but research has also indicated its utility for some adults (Donohue et al., 2009). The fact that Hannah’s mother attended treatment could also be considered a significant component of her treatment process given that the mother-daughter relationship is a crucial one (Henderson & Boyd, 1997). Williams (2013) also discussed the role of significant others (and peers) in contributing to recreational drug users desisting from drug taking, highlighting that relationships are crucial to all levels of drug taking.

## Peer Relationships

Peer relationships can also have a significant impact on substance use treatment and its outcomes (Kelly et al., 2010). Ties with deviant peers can impact treatment entry and success, with those reporting more ties with deviant peers having poorer treatment outcomes, especially if those peers are substance users and less supportive of treatment (Broome et al., 1997; Kelly et al., 2010). Whilst many entering treatment sever ties with peers from their past, they may also form relationships with new deviant peers during treatment (Gandhi, Kavanagh, & Jaffe, 2006). Cutting ties with friends and acquaintances was a factor mentioned by most of the current participants. However, many also mentioned the support of their friends and what they did that supported them.

*“I was prepared to lose a lot of friends and start again. I had another friend who was supportive. Practical support, kind words, a lot of listening. – Rebecca (49, drug treatment, interviewed via phone).*

*“My friends have all been very supportive. There was one I had to ease out of my life. I discovered it really wasn’t a good friend.” – Sarah (45, alcohol treatment, interviewed via phone).*

*“Some of my friends are just alcoholic drug addicts, so I had to cut them off. I’m lucky I have some good friends that are clean, and ones that aren’t, what you would class as alchie drug addicts, there’s only a few I kept, my very best, but they are very happy I went there.” – Melissa (39, alcohol treatment, interviewed via phone).*

Melissa’s account of her experiences is fraught with stigmatising language, referring to ‘addicts’ and ‘alchies.’ She also uses the term ‘clean’ to denote those who do not use drugs or alcohol, suggesting that those who do use substances are dirty or otherwise unworthy. These

terms are derogatory and demeaning, with the use of ‘clean’ associating substance use with filth, and ‘alchie’ denying the distinction between the individual and their illness, reducing their dignity and humanity (The National Alliance of Advocates for Buprenorphine Treatment (NAABT), 2008). Melissa also referred to herself as an “alchie” indicating that she still views herself in stigmatising, negative terms, continuing to associate herself with other stigmatised women who use substances. This language reflects a great deal of self-stigma as discussed in Chapter Five given Melissa’s reference to herself in similar terms.

The experiences of women in the current study suggest a need for women in treatment to be selective of the support networks they surround themselves with. Practical support and a listening ear were also important to these women. Instrumental and affective support, along with participation in normal roles significantly predict less criminal and drug using behaviours (VanDeMark, 2006; VanDeMark, 2007). Affective support through participating in peer support groups is associated with reduced alcohol consumption in alcohol-dependent populations, as well as increased abstinence in those recovering from substance dependency and mental illness (Magura et al., 2003; Walton, Blow, & Booth, 2000; Weisner, Delucchi, Matzger, & Schmidt, 2003). However, most of the research on the utility of social support and improved substance using behaviours involves those with problematic alcohol use, with a lack of evidence for its utility in those with problematic drug use (VanDeMark, 2006). The current study addresses this gap, sharing the experiences of women who used both drugs and alcohol. There is also a need for more research regarding the impact of social support on substance use for women (VanDeMark, 2006). Support from employers was also mentioned by some of the women in this thesis as beneficial in their treatment experience. Emily described how her employer allowed



her to maintain meaningful employment whilst still attending treatment, something which undoubtedly supported her ability to remain substance free.

*“When I went to the programme three days a week I said to my boss that I had to give up work to attend the programme. He asked why, and I told him, and he said no, you’re staying and we’ll just work something out. So, I just worked around my programme basically, which was awesome.”* – Emily (51, alcohol treatment, interviewed via phone).

Relationships with treatment providers and other women in treatment were also important to these women. A good rapport with treatment providers, facilitators and other women in treatment was central to a positive treatment experience for the women interviewed for this thesis.

*“I’ve made a couple of really good friends, and its opened up a lot of doors with all the resources the community has to offer.”* - Sarah (45, alcohol treatment, interviewed via phone).

*“The support of the women, and also the facilitators. I get on with them quite well.”* – Melissa (39, alcohol treatment, interviewed via phone).

### **Staff Attitudes**

As discussed previously, the attitudes and behaviour of staff are crucial to successful treatment experiences (Raeside, 2003; Watson, Daly & Zimmerman, 1980), as is the client-provider therapeutic relationship (Hoxmark & Wynn, 2010; Marsh, Shin, & Cao, 2010; Shin, Marsh, Cao, & Andrews, 2011). Most women in this study spoke highly of the facilitators and treatment providers. The women in the group interview also frequently mentioned the positive influence of the treatment staff. Those interviewed in VanDeMark’s (2006) study spoke of the

beneficial qualities of individual staff members and treatment providers such as patience, non-judgmental attitudes and a sense of humour as important in their recovery.

Peer relationships and knowing that others had been, or were in the same place as themselves was also encouraging to women in the current study.

*“The major thing that kept me focused were other people’s stories of being in the same places and where they were going.” – Rebecca (49, drug treatment, interviewed via phone).*

Rebecca highlights the importance of shared experiences, of knowing that other women have been through the treatment process and sharing experiences and advice to help each other through. Peer support, particularly peer-based programmes can also improve mental health outcomes (Hay, Henderson, Maltby, & Canales, 2017). Larson (2015), Sanders (2011) and DeLucia et al., (2015) found that opportunities to learn from other women in treatment were prevalent themes in their studies, reflective of Rebecca’s experience. Vourakis (1989) used the term ‘groups like me’ to describe instances where groups of women in AA shared similar experiences or stages of ‘recovery’, groups which they purposefully sought out to feel more comfortable in treatment. The commonality of this theme in both previous literature and the current study indicates its centrality and importance in women’s experiences of substance use treatment. It also suggests that the women in the current study experienced elements of treatment similar to women in the international literature, indicating that some aspects of treatment may be homogenous.

*“That there’s ability to change, and (there) were a lot of really good conversations around people holding hope for me, and belief that I can do it. Meeting other people in*

*recovery and meeting a whole array of interesting people that I can identify with. I found my voice.” – Rebecca (49, drug treatment, interviewed via phone).*

*“I went to a twelve-step meeting and all of these other people talked about it. They talked about going to (treatment facility) and they talked about being in recovery, and they talked about their history of using, which was the same as mine. So, I heard that what I was doing wasn’t that unusual and that it could be different. So, I kind of got inspired by all the other people I heard.” – Hannah (39, alcohol and drug treatment, interviewed via phone).*

Hannah’s experience signifies the importance of self-help and mutual-aid groups for many in recovery. Involvement in self-help and mutual-aid groups such as AA and NA predicts positive outcomes regarding substance use, involvement was a stronger predictor than meeting attendance (Mongomery, Miller, & Tonigan., 1995). Kissman and Torres (2004) highlight how these groups enable opportunities to share stories and gain assistance in reframing negative emotions. Turpin and Shier (2017) also discuss how shared treatment experiences help to develop trust and common understanding. Mutual support from peers also helps to combat isolation (Turpin & Shier, 2017) created through the experiences of stigma and the impacts of co-occurring conditions.

Support from other women in treatment was also a positive treatment experience mentioned by many of the women in the current study, and a factor in their treatment success. Most of the literature regarding social support from others in treatment focuses on 12-step and other self-help and mutual-aid groups, however, the women in this thesis also found it in other forms of treatment such as women-only groups offering a holistic approach.

*“I just ended up going to the women’s group, because I prefer to go to a women’s thing... I go there because I know it’s safe and its women. Not that I hate men, for me it’s just safer” – Melissa (39, alcohol and drug treatment, interviewed via phone).*

*“I have some male issues stemming from my childhood, so for me to feel safe and want to open up it’s really hard when there’s guys around. So, to have that forum where it’s just women is really good.” – Sarah (45, alcohol and drug treatment, interviewed via phone).*

Involvement in these women-only groups, as well as NA and AA and utilisation of their social support, is associated with increased likelihood of abstinence through their direct function of abstinence support (Kaskutas, Bond, and Humphreys, 2002). The importance of relationships with other women in treatment was also supported by Larson (2015) and Bond (2013), with Bond (2013) describing how connections with other women in treatment enabled women in her study to form mutual empathy, and gain empowerment.

### **Reconnecting to Life**

A final aspect of connections and relationships is the opportunity that treatment gave these women to reconnect back to life outside of substance use. After significant periods of time caught up in the day to day isolation and disconnect of substance use, treatment enabled the women in the current study to reconnect with themselves and their place in the world.

*“I was quite an angry person, drinking and things made me totally different. So, now, being sober, I’m not like that anymore. The group has given me more confidence. I’m coming out of myself a bit more. They are really supportive, and it’s just quite an important place for me.” – Melissa (39, alcohol treatment, interviewed via phone).*

*“I learned that I could laugh without being wasted. I learned that I could handle being around forty other people, twenty-four hours a day without having conflict. I learned*

*how to just live normally, like make my bed, brush my teeth, have a shower every day, have three meals, cook, think of other people apart from me. So, I guess the benefits were about being in a community and that sense of belonging... I never got what I wanted. I wasn't given the instant gratification, and I couldn't manipulate.... I think it's really important to keep it tough, to keep it fair, and to teach people to be accountable... They gave me a life. They gave me a life where I wasn't just obsessing about getting wasted all the time. They taught me to like who I was."* – Hannah (39, alcohol and drug treatment, interviewed via phone).

Hannah's quote highlights the essence of reconnecting with the world and self in treatment. She had to re-learn how to live in a world with others, doing daily tasks that most people take for granted. Her treatment experience in the therapeutic community<sup>39</sup> enabled her to re-learn these skills in a safe and encouraging environment, finding benefit in the relatively strict regimes of the TC. Treatment also gave Hannah the opportunity to reconnect with herself and grow her self-esteem, an important aspect of substance use treatment for women (Barris, 2004; Johnson, 2000; Wilke, 2000).

Self-esteem groups were mentioned frequently by women in the current study as a hugely beneficial and positive aspect of their treatment, which has had lasting impacts on their wellbeing. This further demonstrates that treatment is about more than abstinence or reducing substance use.

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<sup>39</sup> Therapeutic Communities (TCs) are a common form of long-term residential treatment with a recovery focus. TC's examine the whole person and lifestyle changes, not just abstinence, with individuals living together, actively participating in group living and activities to drive personal change. The aim is for an individual to leave TCs not only substance free, but also employed or bettering their education (NIDA, 2015b).

*“I think the key to the treatment I have been having, and why it’s been life-changing, is the self-esteem group. It really challenges the core beliefs you get when you’re a child. I’ve watched some women change so much through these groups, including myself. I walked in there such a broken person. I was walking with a walking stick, I wore all black, I had my head down all the time. The only piece of black clothing I own now is my leggings for when I work out. I can walk in there now, up the stairs, with a bright smile on my face, wearing colour.”* -Sarah (45, alcohol and drug treatment, interviewed via phone).

*“There’s this self-esteem group that’s quite good. It would probably be my favourite group to go to.”* – Melissa (39, alcohol and drug treatment, interviewed via phone).

Women with problematic substance use are more likely to have poor self-esteem than the general population, often stemming from their increased likelihood of experiencing abuse during their lifetime, and the stigmatization experienced as a substance-using woman (Nelson-Zlupko, Kauffman, & Dore, 1995; UNODC, 2014; Wilke, 2000). Given that poor self-esteem can contribute to substance use, it is important to address self-esteem and other underlying factors in treatment (Barris, 2004, Wilke, 2000).

The experiences of women on Methadone regarding connections and relationships were similar to women receiving other treatments. However, even amongst this sample, there were some differences. For example, Nicky did not have anything to say about support from friends and family, as she did not tell them she was entering treatment, as with Sarah, whereas the majority of the other women in the current study did tell someone. This reluctance to tell family may reflect the increased stigma experienced by women on MMT compared to those who use alcohol or legal drugs. These differences once again highlight the importance of recognising

diverse needs and providing treatment with these in mind. When asked if her friends or family supported her decision to enter treatment Nicky responded

*“I never asked them”. – Nicky (69, Methadone, interviewed via phone).*

This lack of available support from friends and family did not appear to impact Nicky’s treatment or her experiences of it, suggesting that the provision and need for support in treatment is an individualised and personal choice. Women should have the option to include or not include significant others.

Alice mentioned encouragement from her mother, but also did not have much support from friends.

*“I didn’t tell people really, apart from my parents... My Mum had seen all the problems I had had and she was fully supportive of it. My Dad hadn’t had a lot to do with me in recent years up to that, so yeah, he didn’t have a lot of input on that.” – Alice (31, Methadone, interviewed via Skype).*

Both women had relatively positive experiences with service providers, except for Alice’s interactions with a pharmacy mentioned previously.

*“I found them really good and understanding, and non-judgmental for the most part” – Nicky (69, Methadone, interviewed via phone).*

These findings suggest that the social and relational aspects of the Methadone treatment experience were not very different for Alice and Nicky than the social and relational experiences of women in other treatment modalities. It is important to note that this was only the experience of a small number of women on Methadone and may not be reflective of the general social and relational experiences of all women in treatment.

In summary, connections and relationships were important in the treatment experiences of many of the women in this thesis. Connections with friends and family were often important, particularly the need to remove friends who were still using. Relationships and interactions with treatment providers and other women in treatment also shaped the treatment experience, with shared experiences particularly powerful in making women feel comfortable and like they belonged. Facilitators and treatment providers who were kind, caring and non-judgmental were crucial in the positive experiences of treatment held by many of these women. The connections to self and the non-substance using world that treatment provided were also beneficial. Attending treatment allowed many women to reconnect with the world and themselves, something they lost in the isolating journey of problematic substance use.

### **Knowledge**

GPs and other treatment providers are important sources of information about substance use treatment options and recovery. However, many do not have the necessary knowledge to effectively provide this information (Polydorou, Gunderson, & Levin, 2008). GPs and other primary care physicians are the gatekeepers to the health care system and are in a unique position to identify and intervene early with substance use issues (Josiah Macy Jr Foundation, 2000), however, many studies suggest that there are enduring deficits in physicians screening, diagnosis, and management of substance use (Ram & Chisolm, 2016). Health professionals' knowledge and incorporation of the unique treatment needs of women is also crucial to successful and positive treatment experiences for women (Centre for Substance Abuse Treatment, 2009), as evidenced by the overall positive experiences of the current participants, discussed in the previous section on connections and relationships. Women entering treatment have differing needs than those of men including self-esteem work, parenting skills and responsibilities, social



and economic restrictions, trauma support around abuse, mental and physical health needs, interpersonal skill development and relationship work (Nelson-Zlupko et al., 1995; Sena, 1999; Yang, 1990). Knowledge of their own needs is beneficial to women in recovery, with women in Sena's (1999) study recognising that the most important needs during and after treatment were: learning to have a relationship with themselves, developing relationships with others, and being involved in a structured programme (Sena, 1999).

A lack of knowledge on where to seek help and of available services by GPs was frequently cited by women in this study, making it a salient theme to explore, with knowledge crucial to informed decision making. This section of the chapter will explore the women's experiences of treatment providers' knowledge about treatment options and where women could get help. A lack of knowledge on how to treat addiction is also examined. The discussion will then move to the publicity of treatment options, or lack thereof, before moving onto treatment providers' knowledge and inclusion of women's unique needs in treatment processes. The chapter will end with an examination of any differences in experiences regarding knowledge for those on Methadone.

Information is crucial in making informed decisions about treatment entry, yet the findings of the current study suggest that many women wishing to change their substance-using behaviours do not know where to access help. A lack of knowledge about where to get help for substance use issues was frequently cited by women in this study, particularly regarding GPs' lack of knowledge and awareness of available services.

*“In my experience with GPs, I didn't even get told about meetings, AA, anything. You have to seek it out yourself. For an active alcoholic, you would have to be pretty*

*desperate to start seeking out that stuff. It's not just there. It's not just open knowledge."*

– Melissa (39, alcohol treatment, interviewed via phone).

*"A lot of the doctors didn't know what was out there for both addictions and mental health. I don't know if that's because places like (treatment organisation), do they actually tell the doctors the right info(rmation) to refer out? My doctor didn't even know about the place, so he wouldn't have thought to refer me there because he didn't know... Nobody is in connection with anybody else. You have to be really proactive in seeking out the help. Unless you do the work to find it, it doesn't come to you..... There is a lot of support out there, but you have to know where it is or have some direction to find it. Once you do, there's a whole new life out there"* – Sarah (45, alcohol treatment, interviewed via phone).

Melissa's experience highlights the importance of access to information about treatment. Having to actively search for treatment options when an individual has already made the difficult step of consulting a GP, an exercise made difficult by perceived stigma, may reduce the likelihood that an individual will successfully enter treatment. Given that women are more likely to have co-occurring mental health concerns than men (Centre for Substance Abuse Treatment, 2009; UNODC, 2004), as noted in Sarah's case, treatment knowledge and adequate referral processes are crucial. A lack of integrated services to treat mental health and substance use also contributes to difficult treatment experiences for those with co-occurring mental health concerns (Todd, 2010), with recommendations for alcohol and drug services to be funded and partially integrated into mental health services (Todd, Sellman, & Robertson, 1998). Sarah also alludes to the importance of communication and connection between treatment providers and other healthcare workers. Women are more likely to seek help from primary care, social or mental

health services, therefore, knowledge sharing between these services is imperative to adequate service provision (National Research Council, 2006).

Knowledge also enables physicians to adequately diagnose SUDs. Worryingly, statistics suggest that many physicians are either misdiagnosing SUDs or missing the diagnosis entirely. A survey in the United States by the Josiah Macy Jr Foundation found that 94% of primary care physicians (excluding paediatricians) failed to include substance abuse in the five diagnoses they offered when presented with the early symptoms of alcohol abuse in an adult patient (Josiah Macy Jr Foundation, 2000)<sup>40</sup>. Furthermore, only one-in-five physicians surveyed considered themselves ‘very prepared’ to identify problematic alcohol use, lacking confidence in their ability to do so, with most patients (54.8%) agreeing that physicians do not know how to identify problematic substance use (Josiah Macy Jr Foundation, 2000). These findings reflect the conclusions of Millette and Cort (2013) who argued that failing to recognise and discuss substance use issues with patients may be caused by being reluctant and feeling ill-equipped to discuss the issues with patients. The survey by the Josiah Macy Jr Foundation (2000) suggests that a lack of adequate training is a contributing factor in missing a diagnosis of problematic substance use. The majority of physicians (63.2%) in this survey also often counselled individuals with drug or alcohol problems rather than referring them on to specialist counsellors or treatment, with only 46.3% of patients reporting that their physician offered a referral or counselling (Josiah Macy Jr Foundation, 2000).

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<sup>40</sup> This study was conducted before the updated DSM was published, which now uses the diagnosis of Alcohol Use Disorder and Substance Use Disorder. Therefore, the terms ‘substance abuse’ and alcohol abuse’ have been left in the description of the findings.

The women in the group interview also discussed a general lack of publicity of available treatments. They referenced a need for publicity outside of the health system, with advertising campaigns on radio, television and billboards suggested. However, little academic research exists on the advertising of treatments, suggesting this is a recommendation yet to be investigated on an academic level. Although, Brown (2009) does argue that information about available services needs to be accessible where women in need and their families will see it. The need for services to advertise in such a way that encourages access to treatment is also necessary (Brown, 2009).

In their treatment stories, women interviewed for this thesis also experienced differing levels of health professionals' knowledge on treating problematic substance use.

*“My biggest thing with the doctors and nurses is that they don't really understand addiction and mental health. My doctor will do anything for me, but he doesn't really understand. He didn't know the resources like (treatment organisation) or where to even send me when I said I was giving up drinking.”* – Sarah (45, alcohol treatment, interviewed via phone).

*“I've been to doctors to try and give up alcohol and they give me Diazepam (a Benzodiazepine used to treat anxiety, alcohol withdrawal and muscle spasms), which is highly addictive, and I just thought, what's the point in giving an addict something that is highly addictive? This doesn't make any sense.”* – Hannah (39, alcohol and drug treatment, interviewed via phone).

The experiences of these women suggest there is a lack of knowledge by some GPs on how to treat problematic substance use. Education and training for GPs on best practice for treating problematic substance use could go some way to remedying this, with all physicians

needing at least some understanding of evidenced-based substance use treatment to engage in discussion with their patients (Ram & Chisolm, 2016). Hannah's confusion on being prescribed an addictive substance to treat addictive behaviours highlights how a lack of communication and knowledge can leave individuals feeling unsatisfied with or confused about their treatment (Ha & Longnecker, 2010), a factor which can significantly impact treatment entry, adherence, and trust in health professionals (Crocker et al., 2013; Zolnierek & DiMatteo, 2009). The use of medications to treat alcohol use is common, with medications used at different stages of the treatment process (American Psychiatric Association, 2006; Heilig & Egli, 2006). Whilst the use of drugs to treat problematic alcohol use is an evidenced-based treatment, it was perhaps a lack of explanation and communication which led to Hannah's confusion and questioning of her doctor's knowledge and abilities.

Despite these negative experiences, some women had positive experiences regarding health professionals' knowledge of problematic substance use. Nicky had a positive experience of a mental health professionals' knowledge of rituals in drug use, although, Nicky was unsure whether he was a psychologist or psychiatrist.

*"I talked to the doctor and he understood that people still want to use needles and experiment with needles. That was the doctor I had. He was really good. He understood drug addiction really well. From my understanding, most GPs don't understand it at all. Some try to turn their nose up at people with drug problems."* – Nicky (69, Methadone, interviewed via phone).

Nicky's experience with a mental health professional suggests that at least some health professionals possess knowledge of the complexity of problematic substance use and its treatment. Nicky also expressed her awareness of a lack of knowledge on the part of GPs,

suggesting that knowledge gaps and the need for training and education may be focused at the more general level of health care, with those who have received more specialist qualifications in a more knowledgeable position.

The ritual and social aspects around substance taking, discussed by Nicky, particularly drug taking, are a significant part of the problematic use of drugs (Grund, 1993). Manderson (1995) discusses the symbols of drug taking and the role these symbols play in the 'war on drugs.' It is argued that the law bases its response to drug taking on its obsession with the objects of use, a fixation that is not dissimilar to the obsession held by the drug taker (Manderson, 1995). The obsession with the ritual of drug taking, or potential for, described by Manderson (1995) suggests Nicky's experience is one encountered by many on Methadone who have previously injected drugs, indicating that the lack of health professionals' knowledge about the compelling nature of ritual in drug taking and its impact on treatment compliance has wide-reaching implications.

The Methadone provided in New Zealand, as well as the majority of Australia, is orally consumed and is not safe to inject (Hopwood et al., 2003). However, because of the compelling nature of the ritual of injecting drugs, as discussed by Manderson (1995) as well as Methadone specific reactions, some individuals will try to, or successfully inject drinkable Methadone (Robinson, Kemp, Lee, & Cranston, 2000). Injecting this formulation of Methadone can cause serious health complications including abscesses, vein damage, an increased risk of overdose, and may result in the individual being removed from the programme (Fiellin & Lintzeris, 2003; Hopwood et al., 2003; Humeniuk, Ali, McGregor, & Darke, 2003; Jensen & Gregersen, 1991).

The injection of Methadone, however, is a growing concern. Hopwood et al., (2003) surveyed 206 individuals from New South Wales, Australia who had injected Methadone at least

once, finding that 74% preferred to inject Methadone rather than drinking it. Reasons for preferring to inject included: faster relief from withdrawal when injected than when drunk, liking the ‘rush’ of injecting, dislike of the taste of Methadone, and feeling ill from drinking Methadone (Hopwood et al., 2003). Lintzeris, Lennè, and Ritter (1999) suggest that the rates of Methadone injection also depend on local policies regarding take-home doses.

Gaps in knowledge regarding Methadone are not restricted to health professionals, with a lack of public knowledge about substance use issues and their treatment was also discussed by the women in this study. Alice was the most passionate about it when talking about her experience on Methadone.

*“...General lack of information that’s out there for the average public. People just don’t understand what it’s all about.... For the public, just that it’s not the bad thing that people see it as, that there’s more to it than they know. Just to anybody, get educated before you make snap judgements about us. They come from a place of ignorance and judging, without doing any research. Even doctors as well. If other, like, say, GPs and things like that had a bit more knowledge on the topic as well. Because they’re coming from a place of almost as much ignorance as the general public, and that’s a bit sad really.”* – Alice (31, Methadone, interviewed via Skype).

Alice’s experience highlights the knowledge gaps held by many, not just health professionals. Earnshaw et al. (2013) described similar experiences from participants in their study who believed that the public did not understand what Methadone was used for. Participants in Earnshaw et al.’s. (2013) study thought that whilst some of the public saw Methadone as a treatment, others saw it as an opportunity to continue drug use. Alice’s story emphasises the negative impacts this lack of knowledge can have on the lives of those in

treatment and the interplay between stigma and a lack of knowledge. Education and knowledge also play a significant role in reducing stigma (Corrigan et al., 2001; Morrison, 1980; Penn, Kommana, Mansfield & Link, 1999), which, as discussed in Chapter Five, can have a significant impact on those in treatment.

Despite these negative experiences of knowledge gaps in treatment, the service providers interviewed did appear to have some knowledge and understanding of the unique needs and experiences of women in treatment. Amanda discussed her knowledge of the differences she believed women experienced compared to men in treatment. She discussed women's added responsibility of motherhood, and how women were far less likely to self-refer to treatment than men, often because of their role as a mother. Amanda also acknowledged this lack of self-referral may be a consequence of the added judgement and stigmatisation that is experienced by many substance-using women. Amanda believed these differences impacted women's treatment success because they were less likely to enter treatment because of them. This knowledge is supported by an extensive amount of literature discussed throughout this thesis, however, there is evidence to suggest that many women do self-refer and are more likely to do so than men (The National Treatment Agency for Substance Misuse, 2010), indicating a lack of consensus on the likelihood of self-referral. Amanda's suggestion that women are less likely to self-refer may be based on personal observation in the New Zealand context, potentially explaining this difference. Emily also expressed knowledge of the need for accessible treatment, along with the added stressors of motherhood on women in treatment.

*“They’ve (women) got so many more worries, usually with children. Women seem to be the ones who take on responsibility for everything, providing for the household, with kids,*



*that sort of stuff. There's just those barriers there.*" – Emily (51, alcohol treatment, interviewed via phone).

This part of the chapter has focused on and examined the lack of knowledge women experienced regarding available treatment options. The women themselves were often unaware of where they could seek help because of a lack of knowledge on the part of their nurses and GPs of available treatment options.

Treatment is more likely to be successful when client and provider have similar views on treatment plans and outcomes (Joosten et al., 2009). Therefore, the knowledge possessed by these treatment providers would aid their ability to form positive relationships with their clients and to understand their treatment needs, as discussed above by Emily, formulating a mutually agreed upon treatment plan. Whilst the knowledge held by these treatment providers is encouraging, this is only the perspective of two treatment providers and is not representative of all treatment providers in New Zealand. Furthermore, both treatment providers were female, with one having a history of substance use and treatment seeking herself. This may have influenced their knowledge base.

The experiences of Nicky and Alice suggest that women on Methadone may have similar experiences to women receiving other forms of treatment regarding a lack of knowledge on the part of GPs. As their quotes demonstrated, both mentioned GPs as lacking knowledge and exhibiting ignorance and judgement towards Methadone and those on the programme. Nicky's experience suggests that health professionals with more speciality may have additional knowledge. However, a lack of knowledge by the general public can have lasting consequences.

The stories of these women suggest a need for more education and training for nurses and GPs, who are often the first step in the treatment-seeking process. In the United States there has

been an increase in the acknowledgement of the need for education and training around substance use disorders and their treatment in medical school (Polydrou et al., 2008), although, it is also argued that more is required (Ram & Chisholm, 2016). This education and training needs to focus on providing guidelines for treating addiction, as well as information on where to refer clients. Increased communication between service providers on available treatments would also be beneficial, as would publicity of available treatment options outside of the primary care sphere.

## **Chapter Seven: Room for Improvement**

Despite their overall positive experiences, the women interviewed for this thesis suggested several ways in which their experiences could have been improved and recommendations for services going forward. Practical changes were frequently cited, including a need for shorter wait times, more choices about treatment type and location, more options for women, especially those with children, and more mobile services. A change in the attitudes of treatment providers and how they interact with women, and changes to the environment in which treatment is provided were also recommended. The theme of ‘room for improvement’ is used to capture the many thoughts and experiences of these women on what needs to change about the way alcohol and drug treatment is provided to women in New Zealand, or what participants would have liked to have experienced in their treatment journeys. Recommendations for improvement were crucial in this thesis because it provided study participants with a voice to share what did not work for them. This sharing of experiences has the potential to improve the experiences of future clients, and those still in treatment. This chapter will examine the various areas in which women would like to see changes and improvements. Discussions will begin with an examination of what could be considered practical elements of treatment such as access and wait times. The discussion will then move to the treatment environment, funding and the ‘attitude’ surrounding the treatment environment. The importance of improvements to the way mental health is dealt with in substance use treatment will also be discussed. The chapter will end with a discussion surrounding recommended changes to the Methadone programme.

### **Wait Times and Waiting Lists**

As with the international literature, women in the current study raised concerns over the length of wait times to access and enter treatment. Long wait times and waitlists are a significant

deterrent to treatment entry for many, especially women, impacting their rates of treatment entry (Downey, Rosengren, & Donovan, 2003). Substance users report that wait times are a barrier to treatment entry, with some giving up on treatment and continuing to use or seeing periods of sobriety whilst waiting for treatment as a sign of not needing treatment (Redko et al., 2006). Whilst the provision of ‘treatment on demand’ has increased in the United States between 1990 and 2000, and fewer patients are being turned away, this was dependent on how treatment services were funded (Friedman, Lemon, Stein, & D’Aunno, 2003). Private, for-profit treatment services were twice as likely to provide treatment on demand, but were seven times more likely to turn patients away. Services who provided treatment to poorer, lower-socioeconomic populations were less likely to offer treatment on demand, but less likely to turn people away (Friedman et al., 2003). However, there is a lack of research regarding treatment on demand in New Zealand, and the social and cultural contexts differ between New Zealand and the United States, making it difficult to generate comparisons. In this same United States study, Methadone Maintenance programmes were less likely to offer treatment on demand, but more likely to turn patients away (Friedman et al., 2003). These findings suggest that, although the provision for more timely treatment has increased in the United States from the 1990s, problems of accessibility persist for those of lower socioeconomic status, and those on Methadone (Friedman et al., 2003). Carr et al. (2008) identified individual and systemic factors contributing to wait times for problematic substance users in two clinical trials in Ohio. Analysis indicated that longer wait times were related to being court referred, a lack of belief in having a substance use problem and a lack of desire for change (Carr et al., 2008). Shorter wait times to enter treatment were predicted by having a case manager, being ready for treatment and less severe alcohol and employment problems (Carr et al., 2008). There is mixed evidence for the impact of age and

gender on wait times, with some studies indicating that women wait longer to enter treatment than men (Downey et al., 2003), whilst other studies find no gender difference (Carr et al. 2008). There are also inconsistent findings for the impact of age on waitlist placement (Carr et al., 2008). Evidence also suggests that longer wait times lead to greater pre-treatment attrition (Kaplan & Johri, 2000). Pollini, McCall, Mehta, Vlahov, and Strathdee (2006; as cited in Carr et al., 2008) also found that injecting drug users did not enter treatment because of being placed on the waitlist. The evidence for the impact of waitlist placement on retention in substance use treatment is also mixed. Bell, Caplehorn, and McNeil (1994) found that a longer delay before starting treatment because of a waitlist increased dropout rates once in treatment (Carr et al., 2008). Although reducing wait times may not reduce attrition in treatment (Alterman, Bedrick, Howden, & Maany, 1994), waitlists can also impact on wider society, with social costs from waitlists including crime, unnecessary healthcare utilisation, and the disbursing of social programme benefits (Carr et al., 2008). Adamson and Sellman (1998) found that Methadone clients in New Zealand on a waitlist to enter treatment engaged in drug and property-related crime. When patients were not on a waitlist there was reduced criminal behaviour and criminal justice costs, as found in Koenig et al. 's (2005) study of substance users in Ohio<sup>41</sup>. Criminal behavior, other than substance use, was not addressed in the current study. However, wait times were mentioned by some women in this study, particularly treatment providers, as an area needing improvement.

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<sup>41</sup> It is worth noting that the drug-crime connection is a widely debated issue, and one should not uncritically associate drug use with criminal activity, and, therefore, treatment entry with reductions in criminal activity. Space constraints do not allow a full discussion of the critiques of the drug-crime connection. See for example Bean (2008); MacCoun, Kilmer, and Reuter, (2003); and Hammersley (2008).

*“Treatment times are too long to wait to get into anywhere normally. It would be nice for more immediate type, you know, when people are ready and they have to wait three months to get into anywhere, it’s so easy for them to drop off.”* – Emily (51, alcohol treatment, interviewed via phone).

*“I was really lucky, I didn’t have to wait for a long time to get in. So, I guess, for more people to have access.”* - Hannah (39, alcohol and drug treatment, interviewed via phone).

The acknowledgment of the impact of wait times by service providers suggests that at least some service providers are aware of this restriction in providing quality treatment to women, and the need to remedy the long wait times experienced by some women. Emily’s discussion of the drop out that can happen with wait times also reflects that found in previous literature, indicating some awareness of research in this area.

### **Treatment Access**

Other aspects of treatment access were also discussed by women in this study, indicating that accessing treatment was a significant aspect of their treatment journeys.

*“Treatment closer to home is always good, rather than having to travel. More peer support, more access to talk therapies.”* – Rebecca (49, drug treatment, interviewed via phone).

*“More mobile services, make it more accessible for people to get to the services, or the services go to them.”* - Emily (51, alcohol treatment, interviewed via phone).

Treatment accessibility is particularly difficult for women, who find it difficult to find and finance childcare options, and who may also lack the financial resources and access to transport to travel to treatment services (Greenfield, 2002; Levy, 2014). Mobile treatment options, whereby services travel to clients’ homes or nearby health centres are a useful tool for

increasing treatment access (Hall et al., 2014). Emily's service offered this option for their clients. However, more services offering this option would be beneficial. Rebecca also mentioned the importance of peer support services. These services involve those who have been through treatment working with those currently going through treatment to assist and mentor them to maintain long-lasting recovery (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Solomon, 2004). This facilitates shared experiences, as well as the peer support worker acting as a good role model for the client (Bassuk et al., 2016). A systematic review of nine studies examining peer support interventions and services indicated that peer interventions positively impacted the lives of those with SUDs (Bassuk et al., 2016). However, no women in the current study directly commented on peer support services regarding their own treatment experiences, negating the opportunity for comparison to Bassuk et al. (2016).

Access to treatment also necessitates having a range of treatment options to account for clients varying needs and preferences. As discussed in Chapter Two, there are many different types of treatment for substance use disorders, however, the stories of some women in the current study suggest that there need to be more options and better access to them. This is particularly the case for women with children.

*"If there were more facilities for women, and perhaps, women with children."* – Hannah (39, drug and alcohol treatment, interviewed via phone).

*"There should be a few more choices about where you can do treatment if you just want to be a woman. There needs to be some recognition that hormonally and emotionally there needs to be more support. The second time I went through treatment I had a child. She was three. I turned up to an appointment and I brought her with me. There was nothing in the waiting room. I didn't feel comfortable talking about things in front of her,*

*and it was just really unfriendly for that environment, the waiting room, the space. She was shocked. Some support with parenting. If you're going to be unwell for a few days then they really need to put some resource, and by that, I mean money, into supporting the family to make that happen, and a notification to CYFS (Child, Youth and Family Services) isn't going to help either."* – Rebecca (49, drug treatment, interviewed via phone).

Rebecca alludes to the physiological and emotional differences between men and women and the impact this can have on both substance use and treatment (Buccelli et al., 2016; Greenfield, Back, Lawson & Brady, 2010). Recognising these differences and having treatment options which respect and adequately address these differences is crucial to successful treatment outcomes. Rebecca's experience also highlights the additional complications to treatment that being a mother can bring. Women are more likely than men to be the primary caregiver for children (Greenfield, 2002), resulting in them being more likely to be bringing them to appointments, or struggling to find childcare arrangements. Both funding and environmental considerations were mentioned in Rebecca's story, factors also mentioned by other women.

Rebecca experienced the treatment setting as an environment not suitable for her child, which left her feeling disillusioned with the treatment process and the extent to which treatment providers are responsive to women's needs. She also described other aspects of the treatment process which created a negative environment and first impression.

*"The place was an old house. You walked into the waiting room and there was glass in front of the reception. You had to wait for the receptionist or whoever was on the counter to come out. This was not environmentally friendly. Wooden seats around the walls and*



*a few magazines, fairly sparse. The people themselves were pretty good.” – Rebecca (49, drug treatment, interviewed via phone).*

This was Rebecca’s experience of a service in the 2000s, and so, one would hope that improvements have been made. However, Rebecca’s experience does highlight the need for services to provide spaces that are welcoming, respectful and create a safe space. Rebecca also discussed environment in terms of the group environment and how it made her feel. She was again referring to her experience in the early 2000s.

*“I remember going to a women’s AOD (Alcohol and Other Drug) group at the (names treatment provider). It was okay, but sometimes you just want to go in and not be asked your name, date of birth and please sign here. There’s no anonymity to anything these days. They’re doing a role, sometimes it’s just not that welcoming, the group environment, the AOD treatment because it’s a good way of getting the masses through. The groups were hard work to make a connection.” – Rebecca (49, drug treatment, interviewed via phone)*

Funding was also mentioned by some women in the current study as needing increasing, with a need to also look at where the money is being spent.

*“I thought at the time, what I needed, and what I had on the goals, was that I could really use some massages. Was there any money I could get from anywhere to go and get some massages once a week? Nothing, there’s nothing like that. There’s just no money to have a recovery.” – Rebecca (49, drug treatment, interviewed via phone).*

The need for a holistic approach to treatment and the services offered was again highlighted in Rebecca’s experience. Looking outside of substance use is important, as multiple social, emotional and economic factors can influence substance abuse (Lyman, 2017). Providing

women with healthy coping strategies and stress reduction techniques in recovery can reduce life stress, and therefore, the likelihood of relapse (Sinha, 2001; Vallejo & Amaro, 2009).

Melissa also discussed funding and money allocation, and what it means for people in treatment. She also discussed the importance of problematic substance use education in schools, and education surrounding what resources are available.

*“I think it should be in schools, where you can go if you find yourself in trouble. I don’t think there is enough effort put into dealing with alcoholics and addicts in society.*

*There’s not enough money being put into it, whereas the jails are full. When I was there (in prison), it was easily half to three quarters who were alcoholic drug addicts.” –*

Melissa (39, alcohol treatment, interviewed via phone).

Evidence for the utility of substance use education in schools is mixed, with Bangert-Drowns (1988) meta-analysis of school education programme evaluations finding that typical substance use education was most effective with increasing knowledge and changing attitudes, but was unsuccessful in changing drug-using behaviour. McBride (2003) also argues that while school-based programmes have progressed, there is room for refinement. School-based programmes generally focus on prevention, education around the dangers of drug use, and reducing substance use through various means (Benard & Marshall, 2001; Strøm, Adolfsen, Fossum, Kaiser, & Martinussen, 2014), however, there is a paucity of literature focusing on the provision of education on where to get help. Given the significant rates of adolescent problematic substance use (Fergusson & Boden, 2011), and the progression from adolescent use to adult use (Grant et al., 2006), education is an important factor in prevention and could be argued to be crucial in increasing awareness of treatment options. Melissa also alludes to the criminalisation of substance use and the impact this is having on the number of people in prisons.

The ‘war on drugs,’ with its focus on the criminalisation of drug use, and subsequent incarceration of drug users, is perhaps the most prominent example of policies surrounding the criminalisation of drug use. Not only has the war on drugs failed to combat drug use, it has exacerbated the harms associated with drug use, and resulted in prison over-crowding (Pelan, 2015). The ‘war on drugs’ has also intensified stigma and made it harder for women to get help.

### **Mental Health Complications**

The complication of co-morbid mental health conditions and the treatment of these alongside problematic substance use was also identified as an area needing improvement.

*“The negative aspects were the complication of anxiety. I wasn’t taken credibly, nor was there any questions going through AOD treatment, or any suggestions about.... No one even asked about anxiety. In fact, I don’t even think they even talked about other aspects of mental health. The focus was just the treatment (in 2000). Nothing about my physical health issues, how to do some really good wellbeing stuff. It was more talked about in 2012, definitely, much more recovery language, much more about physical health.”* – Rebecca (49, drug treatment, interviewed via phone).

Rebecca’s experience indicates that there has been some positive change in the way mental health issues are addressed in alcohol and drug treatment. However, she also suggests that further improvements are needed. On the other hand, Alice had a far more positive experience of mental health support along with her Methadone treatment, suggesting that the provision of support for comorbid mental health conditions are inconsistent, even in a relatively small sample.

*“Here in (names location of treatment service), the programme is very connected to mental health services. There’s a psychiatrist that oversees the programme and also a*

*psychologist available through the mental health service you can see. It's very comprehensive, very holistic. Any issues I have had mental health wise they will deal with.*" – Alice (31, Methadone, interviewed via Skype).

As discussed throughout this thesis, women in alcohol and drug treatment are more likely than men to experience mental health issues, particularly mood disorders and eating disorders (UNODC, 2004). Many women may begin using substances to cope with these conditions (Back et al., 2011; UNODC, 2014), and so, recognition and treatment of mental health conditions in conjunction with substance use is important. Some research indicates the need for services which provide integrated treatment, which has been found to be superior to separate treatment plans for individual disorders (Kelly & Daley, 2013). Many services will only treat substance use or mental health, with individuals with comorbid disorders considered 'system misfits' because of their differences to those with only one illness (Kelly & Daley, 2013). This also reflects the importance of a holistic approach to treatment, as mental health conditions can significantly impact both substance use and treatment, particularly with the aforementioned use of substances to cope with mental distress (Back et al., 2011; UNODC, 2004).

### **Attitudes**

When discussing what these women would like to say to treatment providers, or what they would like to see changed, 'attitude' was a theme mentioned by many women, including treatment providers themselves. As discussed previously, the attitudes of professionals can significantly impact treatment experiences and treatment outcomes (Gjersing, Waal, Caplehorn, Gossop, & Clausen, 2010). A need for treatment providers to hold a holistic and hopeful attitude was mentioned by Rebecca.

*“Be patient, hold hope, look at the whole person, not just pick out that part. Treat them like a person, not a number. Let them have a voice, let them look at goals outside of stopping using and have you got somewhere to live. See the person, not the problem.”* –

Rebecca (49, drug treatment, interviewed via phone).

Melissa also mentioned a need for service providers to be genuine, and to adequately respect the struggles of overcoming problematic substance use.

*“I can see if someone actually cares or not. Some that I have dealt with, they just don’t know what it is like to live that life. They seem to think you can just stop, or you can do x, y, and z and you will be pretty much cured.”* – Melissa (39, alcohol treatment, interviewed via phone).

Melissa’s experience alludes to previous themes discussed in this thesis, particularly the value of positive relationships with treatment providers and the need for education of treatment providers. Her experience also further highlights the value that peer support and advocacy services can provide for women in drug and alcohol treatment. Had Melissa been in contact with a peer worker who had been through the journey of substance use and treatment, she may not have felt as misunderstood and that her struggles were minimised.

### **Service Providers’ Suggestions for Change and Improvement**

Attitudes were also an aspect mentioned by service provider Amanda when discussing what she would say to policymakers about the way policy and funding impacts treatment provision for women. Due to the recording of Amanda’s interview being damaged, her response is paraphrased from the interview summary.

*They need to get out of their ivory towers and actually speak to the women. To make policies and interventions with women and not for them.* – Amanda (service provider, residential and community treatment, interviewed face-to-face).

Amanda's response highlights the importance of consumers being involved in the treatment process, and the importance of consultation with consumers about the services that are provided. The importance of involving consumers is also referenced by the Ministry of Health (1995). Amanda suggests there is a disconnect between those who make the legal and policy decisions and those impacted by the decisions. She suggests a need for communication between those making these decisions and those receiving the services, further solidifying the importance of the theme of connections and relationships, and the resulting communication and knowledge. Consumers are a valuable knowledge source, but one that has historically been neglected (Ministry of Health, 1995).

Amanda also discussed her visions for the future of her service and what she would like to provide to her clients if funding permitted. Amanda would like to be able to include women's children in the treatment process. A vision of live-in opportunities for children was discussed whereby the children, predominantly under the age of five, would be placed in on-site child care while the women attended groups and counselling sessions, but would share a room with their mothers at night, cooking together, and spending time as a family. Amanda expressed the importance of this for creating a bond between mother and child, which is often dysfunctional, or in some cases non-existent when mothers have problematic patterns of substance use (Parolin & Simonelli, 2016).

The presence of children in treatment can facilitate positive treatment outcomes, with the presence of a child in treatment linked to retention, mental health outcomes and abstinence

(Parolin & Simonelli, 2016). Moreover, contact with a primary caregiver in a child's first five years of life is crucial for the child's development of self-regulation, autonomy, and expectations for relationships (Suchman, Pajulo, DeCoste, & Mayes, 2006). Therefore, the first five years of life offer an important window for therapeutic interventions (Suchman et al., 2006). Amanda's vision for a live-in programme reflects that of a relational approach to interventions for substance-using women, which focuses on the emotional quality of the parent-child relationship to promote optimal child development (Suchman et al., 2006). A successful example from the United States is Families in Transition (FIT), which allows women in treatment to have their children (up to the age of 16) live with them in treatment (Jackson, 2004). The Village South in Miami is a successful FIT programme. The Village South has provided services for almost 800 parents and approximately 2000 children (Jackson, 2004). It is a comprehensive programme offering not only substance misuse treatment for parents, but also services for children including psychological counselling (Jackson, 2004). The Village South incorporates the entire family in treatment (where appropriate) including children and family outside of the residential facility, premised on family systems theory, which proposes that substance misuse helps family members cope with their dysfunctional relationships (Jackson, 2004). Treatment, therefore, aims to remedy and repair these relationships so that substance use is no longer adaptive or disruptive to the family (Jackson, 2004). Whilst more research and funding are required around such programmes, Jackson (2004) argues that the programme has been successful overall, with the majority of women completing the programme, (see Jackson, 2004 for a comprehensive overview of the programme). More of a focus on the impact that maternal substance use can have on a young child, and initiatives to remedy this were also important to Amanda, but something that she believed was limited by funding.

## Experiences on Methadone

Lastly, this chapter will examine the calls for change made by those on Methadone. Whilst the women's experiences on Methadone were positive overall, as discussed throughout the results section, they did experience some issues with the programme. Alice's main concerns and issues surrounding her experiences on Methadone were around the rules and guidelines of the programme, and the impact these have on clients.

*"I've got nothing but good things to say about the people and what they do with the services they have. It's the services that they have, and the rules that they have to go by that I'm a little bit funny about."* – Alice (31, Methadone, interviewed via Skype).

Alice discussed this in reference to the provision of take-home doses and the way that an individual's dose is determined. Once an individual has been stabilised on their dose and the programme, and as a reward for adhering to programme requirements and abstinence, they may be able to receive take-home doses. This allows individuals to take their dose at home and removes the provision of daily visits to the pharmacy or doctor (Walley et al., 2012). To be considered for take-home doses a client must demonstrate stability, reliability and the ability to comply with safety requirements of unsupervised consumption (Ministry of Health, 2014). The number of take-home doses may be increased so that a client only needs to attend a pharmacy or clinic every few days, with these contingent take-home doses associated with longer retention in treatment and survival, as well as abstinence from opioids and increased counselling attendance (Walley et al., 2012).

Alice was disillusioned and unhappy with the lack of consistency between the different programmes she had been in. Some programmes would allow take-home doses for long weekends and public holidays, allowing clients to go away for the break, whilst others did not.



The New Zealand Practice Guidelines for Opioid Substitution 2014 discuss the possibility of flexibility with dosing to reduce the time-consuming nature of daily supervised consumption for those clients who meet take-home dose requirements (Ministry of Health, 2014). However, it does not detail the guidelines for public holiday prescribing, suggesting that how take-home doses are allocated is up to the discretion of individual prescribers. It could also be suggested that the provision of take-home doses is open to the influence of gendered labels and stigma. ‘Good’ women will be provided with takeaway doses – those women who perform ‘acceptable’ femininities, whilst ‘bad’ women will not. Alice’s experience suggests the need for consistency across services with prescribing take-home doses for those who meet requirements.

Alice also discussed the capping of Methadone doses in New Zealand, an aspect that she questioned and did not agree with.

*“One thing that they do here that I don’t agree with as well is doses are capped at a certain level. Generally, if you are a therapeutic level for Methadone, and that’s the only one I can speak of with any experience, is 80-120mg, but the majority of people are okay at that dose range. Well, we actually cap you in New Zealand at 120mg, so anybody that is above that dose range that needs to be above it can’t usually. They will sometimes go over for a particularly big male, it’s about the only people they will do that for, and it’s not for long. They’ll bring them down pretty much as soon as they can.” - Alice (31, Methadone, interviewed via Skype).*

New Zealand Practice Guidelines for Opioid Substitution 2014 do state that service providers may consider a dose above 120mg, indicating that although most clients will be maintained on a dose lower than 120mg, higher doses may be administered (Ministry of Health, 2014). Overdose risk for Methadone is high, particularly in the first few weeks, and so dose

capping is an attempt to reduce overdose risk, as well as the diversion of Methadone<sup>42</sup> (Ministry of Health, 2014). However, a lack of clarity surrounding when a dose will be increased to above 120mg may have led to Alice's disagreement around dose capping. Clearer guidelines, consistency, and communication from service providers could go some way to remedy this, highlighting the importance of communication. Additionally, more flexibility is also required in the prescribing system.

Dissatisfaction with the lack of support she received when coming off Methadone was a significant negative experience for Nicky and one that she would like to see improved for others. Nicky's experience did occur a few years prior to her interview. However, the experience was so central to her story, and could have a considerable impact on others that it warranted discussion.

*"I came off Methadone and I just never got better. Seven months later I was free of Methadone and I was still ill. I rang up to get help, and I couldn't get help from anyone, anywhere. I ended up having to start back on Morphine again to get back on the Methadone. It was a vicious cycle. I was unable to be free of it. They should open it up for discussion for a lot longer than I experienced when you get off Methadone."* – Nicky (69, Methadone, interviewed via phone).

Zajdow (1999) describes a similar experience of one of the participants in her study who was not given enough information about coming off Methadone and the side effects of doing so. This left Zajdow's participant feeling as if she had gone mad (Zajdow, 1999). The experience of Zajdow's (1999) participant, alongside that of Nicky, indicates that a lack of information around coming off Methadone may be a common issue. Longitudinal research suggests that most clients

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<sup>42</sup> Sharing or selling Methadone, rather than using the full prescription themselves.

on an Opioid Substitution programme are unable to successfully taper off the substance (Calsyn, Malcy, & Saxon, 2006). Nicky's experience is reflective of this, relapsing back to drug taking to get back onto Methadone. Many Methadone clients are also fearful of the process of coming off Methadone and withdrawal symptoms (Rubio, 2013). Since the introduction of substitution treatments like Methadone maintenance, there has been controversy surrounding whether substitution treatment should be provided indefinitely, or whether clients should be encouraged to taper off after stabilisation (Calsyn et al., 2006). It has been suggested that because of the negative affective states that can occur when tapering off, clients should be assisted by clinicians during this process (Wermuth, Brummett, & Sorensen, 1987). However, despite additional support through groups such as a tapering network support programme in the United States (Sorensen, Trier, Brummett, Gold, & Dumontet, 1992), clients were not more likely to taper off than those not provided additional support (Calsyn et al., 2006). Those who taper off at a slow rate are more likely to complete the tapering process (Thompson & Tiffen, 2004). Several variables have been identified associated with successful tapering off Methadone including: social stability, employment, stable family and social life, long participation in Methadone Maintenance, staff support for and belief that tapering will be successful, and slow withdrawal (Ekland, Hiltunen, Melin, and Borg 1995, as cited in Calsyn et al., 2006). Staff support appears to be a crucial element of successful tapering, an element which Nicky did not receive. Nicky was desperate for support around coming off Methadone and getting back on when tapering was ineffective, yet she was forced to put her health at risk and re-developed a pattern of problematic drug taking to receive the stability she required. Nicky would like to see more information and support around tapering for those who wish to come off Methadone. There is a lack of research on the available support for tapering in New Zealand, however, the international literature

indicates that support from clinicians is crucial, suggesting a need to incorporate discussions around tapering and how this can be done in a client's care plan.

Nicky also described a lack of support and action on behalf of treatment providers to ease her experiences of Methadone side-effects. These side-effects had a significant impact on her life when she was beginning her treatment, something which has left a lasting negative impression.

*“When I first went on the treatment I got horrendous headaches... I told them (treatment providers) about it, but they couldn't or wouldn't deal with it. They weren't headaches that lasted all day. It was just a headache that completely immobilised me for about twenty minutes and then went away. After that I was okay, but they were really scary, I could barely move my head.”* – Nicky (69, Methadone, interviewed via phone).

These headaches were of significant concern for Nicky, but she was not given any assistance to deal with the pain or emotional impact. Zajdow (1999) discussed a similar experience of one of her participants whose physical symptoms and side-effects were ignored by health professionals, again indicating that this lack of support and acknowledgement of side-effects may be a pervasive issue. Nicky's experiences indicate a need for increased support from treatment providers in all aspects of Methadone treatment, from initiating treatment and the first few months, through to coming off Methadone and exiting the programme.

In summary, despite overall positive treatment experiences, the women in the current study identified several areas for improvement. Improvements to the treatment environment, as well as more treatment options, especially those for women with children, were cited as necessary. A reduction in wait times was also discussed as a needed improvement, as were funding increases to achieve needed services and improvements to the way in which co-morbid

mental health conditions are treated alongside substance use. Improving these areas would have made a significant positive impact on the experiences of these women and suggest important developments for the future. Those on Methadone also suggested their own unique areas of improvement around guidelines and how these can impact on the treatment experience, as well as the unique aspect of coming off Methadone and the support that is needed, but was lacking for women in this study. The outcomes of this section suggest a significant amount of improvement is needed in many aspects of the treatment experience, with these women's voices providing informed and valuable information on what needs to change to improve the treatment experience for women in alcohol and drug treatment in New Zealand.

## **Chapter Eight: Conclusion**

As discussed at the beginning of this thesis, there were two main research aims. The first was to explore women's experiences of alcohol and drug treatment in New Zealand, and the second to explore what needs to change about the way alcohol and drug treatment is provided to women in New Zealand. This chapter will synthesise the key themes, research questions, and results. With a significant lack of research in this area, this qualitative thesis provided an opportunity for women who have received or are receiving substance use treatment to share their thoughts and experiences about alcohol and drug treatment for women in New Zealand. It provided these women an otherwise unlikely opportunity to have their voices heard and contribute to the possibility of change. A feminist methodology informed this research, with semi-structured interviews utilised.

Whilst this thesis is not representative of the stories and experiences of all women in New Zealand who have received substance use treatment, it can address some of the knowledge gaps, and contribute insights into changes needed in drug and alcohol treatment in New Zealand. This platform for sharing experiences resulted in multiple issues being raised in exploring women's experiences of alcohol and drug treatment and what needs to change.

Women experience both problematic substance use and treatment for it in a multitude of different ways than their male counterparts. Gender differences exist in the likelihood, amount and type of substance use, with physiological differences impacting the absorption and outcome of substance use. Childcare restraints, socioeconomic differences, and experiences of stigma, mental health, and abuse impact women's entry into treatment differentially than for men (Brown, 2009; Buccelli et al., 2016; Greenfield, 2002; UNODC, 2004). Whilst literature on women who use substances and those seeking treatment is scarce, the available literature

indicates that women have unique needs regarding treatment for substance use, needs which have historically been ignored and neglected. The impact of financial strain, child care, abuse and mental health were explored in this study, along with the general lack of resources and self-esteem, which all need to be addressed in alcohol and other drug treatment. The literature review also examined stigma and several of the treatment types and options available, with a focus on Methadone.

Four<sup>43</sup> key themes were evidenced in this thesis, with sub-themes also crucial. These themes were: stigma, connections and relationships, knowledge and room for improvement. Connections and relationships were a key part of the women's experiences of alcohol and drug treatment, as well as their motives for entering treatment. These included relationships with friends and family, treatment providers and other women in treatment. What became apparent was an overall positive experience of alcohol and drug treatment in New Zealand by women in the current study, an unexpected finding given the available literature on women's experiences. However, a lack of service provider knowledge and training had a significant impact on the lives of these women, particularly the paucity of knowledge held by GPs on how to treat addictive behaviours and where to refer patients for treatment. A further surprising finding was the study participants' perceived lack of experienced stigma. Most of the women did not identify as having experienced a significant amount of stigma, however, for those who did, it had a significant impact on their lives. Some of the women's responses did evidence self-stigma, particularly in their use of language to describe themselves and their current and former friends,

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<sup>43</sup> Refer to note in Chapter Three about the removal and condensing of the fifth theme 'what is treatment?'

although, many of the participants may not have identified this as stigmatizing, indicating the pervasive and damaging impacts of stigma.

Several of the women in the current study also identified a need for more accessible services, particularly services closer to home and which acknowledged and responded to women's added need for support as mothers. Furthermore, a need for more services and treatment options specifically for women was important to many of the participants. These needs were also endorsed by treatment providers who expressed the need for greater funding to achieve these much-needed improvements. Treatment options need to be holistic, relationship-building, individualized and evidence-based, reflecting the research which indicates that not all substance users seeking treatment want abstinence. A redirection and/or increase in funding, as well as changes in attitudes towards and perceptions of substance-using women and their treatment needs will require significant work within political spheres, policy development and at the community level to make significant, lasting change. However, it is change that is greatly needed, and which can be achieved. The Labour government's review into mental health and addiction in 2018 is a promising start and may provide an avenue for these changes. Many of the improvements suggested by current study participants are also addressed in *Guidelines on drug prevention and treatment for girls and women* (UNODC, 2016), indicating that certain aspects of gender-sensitive treatments are universal across contexts, although, despite this, improvements are slow.

Overall, this thesis has highlighted the varied experiences of women who use substances and who enter treatment. Whilst the participants' experiences were overarchingly positive, there is significant room for improvement, particularly the need for greater access to gender-sensitive services which privilege women's voices and experiences, providing a safe, non-stigmatising,



holistic environment which encourages positive, long-lasting change, whatever that may look like for the woman.

## Appendices

### Appendix A: The 12-Steps of AA and the 13-Steps of Women for Sobriety

#### The Twelve Steps<sup>1</sup>

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

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<sup>1</sup> Alcoholics Anonymous Great Britain, (2018).

Women For Sobriety 13 Steps<sup>2</sup>

1. I have a life-threatening problem that once had me. *I now take charge of my life and my wellbeing. I accept the responsibility.*
2. Negative thoughts destroy only myself. *My first conscious sober act is to reduce negativity in my life.*
3. Happiness is a habit I am developing. *Happiness is created, not waited for.*
4. Problems bother me only to the degree I permit. *I now better understand my problems. I do not permit problems to overwhelm me.*
5. I am what I think. *I am a competent, caring, compassionate woman.*
6. Life can be ordinary or it can be great. *Greatness is mine by a conscious effort.*
7. Love can change the course of my world. *Caring is all important.*
8. The fundamental object of life is emotional and spiritual growth. *Daily I put my life into a proper order, knowing which are the priorities.*
9. The past is gone forever. *No longer am I victimised by the past. I am a new woman.*
10. All love given returns. *I am learning to know that I am loved.*
11. Enthusiasm is my daily exercise. *I treasure the moments of my New Life.*
12. I am a competent women, and have much to give life. *This is what I am and I shall know it always.*

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<sup>2</sup> Women For Sobriety, (2016).

13. I am responsible for myself and for my actions. *I am in charge of my mind, my thoughts, and my life.*

## Appendix B: Interview Schedule for the original study (Methadone)

### **‘Liquid Handcuffs (?)’: The female experience of Opioid Substitution Treatment in New Zealand- Draft Interview Schedule for participants.**

#### Setting the Scene:

1. Which nationality do you identify with?
2. How old are you? “Saying in your 30s is fine.”
3. Are you currently on Opioid Substitution Treatment (OST) or have you done so in the past?
4. What substitute are you taking?
5. How long have you been/were you on OST?
6. Which programme(s) are/were you involved with? Eg: Southland.
7. How frequently do you/did you take your doses of your substitute?
8. Did you/are you also receiving assistance from a counsellor or similar? If so, was this provided with your OST programme, or did you need to seek this help yourself?

#### Interview Questions:

9. What were your motivations behind starting OST.
10. How did you feel about your decision and starting OST?
11. How did your family and friends support/not support you in your decision?
12. How did your decision to start OST impact on your work and/or family life?
13. What do you seek to achieve from OST?
14. What are/were your experiences of doctors, nurses and other OST service providers?
15. What, if any, are/were the negative aspects that you experienced on OST?
16. How did these negative experiences make you feel, and how did they impact your quality of life?
17. What, if any, are/were the positive aspects you experienced on OST?
18. How did these positive experiences make you feel, and how did they impact your quality of life?
19. What do you think needs to change about the way OST is provided to women/what do you want going forwards/ what would you have liked to see changed while you were on OST? (Note: depending on participant responses, more probing questions may be needed here).
20. To what extent have you experienced/did you experience stigma as an OST client?
21. How did this stigma impact your life?
22. If you could tell treatment providers about your experience, what would your main points be? These can be positive, negative or neutral.  
Do you have anything else you would like to add or discuss? (Note: More probing questions may be necessary).

## Appendix C: Interview Schedule for the current study- Women in/seeking treatment

### **A gendered difference: The female experience of drug and alcohol treatment in New Zealand- Draft Interview Schedule for participants.**

#### Setting the Scene:

1. Which nationality do you identify with?
2. How old are you? "Saying in your 30s is fine."
3. Are you currently on receiving treatment of drugs and/or alcohol or have you done so in the past?
4. What kind of treatment are you receiving/have you received?
5. How long have you been/were you receiving treatment?
6. Which programme(s) are/were you involved with? Eg: Southland.
7. How frequently do you/did you attend/receive treatment?
8. Did you/are you also receiving assistance from a counsellor or similar? If so, was this provided with your treatment programme, or did you need to seek this help yourself?

#### Interview Questions:

9. What were your motivations behind starting treatment?
10. How did you feel about your decision and starting treatment?
11. How did your family and friends support/not support you in your decision?
12. How did your decision to start treatment impact on your work and/or family life?
13. What do you seek to achieve from treatment?
14. What are/were your experiences of doctors, nurses, and other service providers?
15. What, if any, are/were the negative aspects of treatment that you experienced?
16. How did these negative experiences make you feel, and how did they impact your quality of life?
17. What, if any, are/were the positive aspects of treatment you experienced?
18. How did these positive experiences make you feel, and how did they impact your quality of life?
19. What do you think needs to change about the way treatment is provided to women/what do you want going forwards/ what would you have liked to see changed while you were receiving treatment? (Note: depending on participant responses, more probing questions may be needed here).
20. To what extent have you experienced/did you experience stigma whilst in treatment?
21. How did this stigma impact your life?
22. If you could tell treatment providers about your experience, what would your main points be? These can be positive, negative or neutral.
23. Do you have anything else you would like to add or discuss? (Note: More probing questions may be necessary).

## Appendix D: Interview guide for Service Providers

### Questions for service providers:

1. What is your role in drug/alcohol treatment?
2. How long have you been involved in drug and alcohol treatment?
3. What differences do you think women experience compared to men in treatment?

(further discussion may follow).

4. How do you think these differences impact their success in treatment?
5. How does your service provide support for women?
6. Do you think that this service could be better tailor its treatment to women, if so,

how?

7. What changes to policy/funding would you like to see for this service, and why?
8. If you could say something to policy makers about what the service needs to better

support women, what would it be?

OST Research  
jaime Flack



## Appendix F: Facebook wording participant recruitment- Original Study

**Text to be accompanied by the poster.**

“Are you a female who has received, or is receiving Opioid Substitution Treatment?

I am a Masters student at Victoria University of Wellington looking to interview females who are receiving, or have received Opioid Substitution Treatment.

The purpose of this study is *to examine the experiences of New Zealand women on OST, their motivations for starting OST, what they seek to achieve from OST, their experiences of service providers, their perceptions and opinions on what needs to change to improve the service and their experiences, and to what extent they have experienced stigma as an OST client, and how this has impacted their lives.*

If you would like to have YOUR VOICE HEARD, please contact me.”

Jaime Flack

MA Criminology Student, Victoria University of Wellington.

Email:

## Appendix G: Participant Consent Form- Original Study



### **‘Liquid Handcuffs (?)’: The female experience of Opioid Substitution Treatment in New Zealand.**

#### **CONSENT TO INTERVIEW**

This consent form will be held for 2 years.

Researcher:Jaime Flack, School of Social and Cultural Studies, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part in an audio recorded interview.

I understand that:

- I may withdraw from this study at any point before May 30<sup>th</sup> 2017 and any information that I have provided will be returned to me or destroyed.
  - The information I have provided will be destroyed 2 years after the research is finished.
  - Any information I provide will be kept confidential to the researcher and the supervisor. I understand that the results will be used for a Masters report and a summary of the results may be used in academic reports and/or presented at conferences.
  - My name will not be used in reports, nor will any information that would identify me.
- 
- |   |                          |                             |
|---|--------------------------|-----------------------------|
| • I would like a copy of the transcript of my interview:                                    | Yes                      | No <input type="checkbox"/> |
|   | <input type="checkbox"/> |                             |
| • I would like a summary of my interview:   | Yes                      | No <input type="checkbox"/> |
|   | <input type="checkbox"/> |                             |
| • I would like to receive a copy of the final report and have added my email address below. | Yes                      | No <input type="checkbox"/> |
|   | <input type="checkbox"/> |                             |

Signature of participant: \_\_\_\_\_

Name of participant: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix H: Participant Information Sheet- Original Study



### **‘Liquid Handcuffs (?)’: The female experience of Opioid Substitution Treatment in New Zealand**

#### **INFORMATION SHEET FOR PARTICIPANTS**

Thank you for your interest in this project. My name is Jaime Flack and I am a Masters student in Criminology at Victoria University of Wellington. This research project is work towards my thesis, and may be used in academic publications and conferences.

#### **What is the aim of the project?**

This project aims to examine the experiences of New Zealand women on Opioid Substitution Treatment (OST). The Victoria University of Wellington Human Ethics Committee have approved this research.

#### **How can you help?**

If you agree to take part, I will interview you at a time and place of your choice. The length of the interview is not expected to exceed 1.5 hours. Interviews will be recorded using a digital recorder to minimise the need for notetaking during the interview. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before May 30<sup>th</sup> 2017. If you withdraw, the information you provided will be destroyed.

This research is confidential. You will be given a pseudonym (fake name) to protect your identity and privacy. However, if you do disclose a risk of self-harm, or harm to others, confidentiality may no longer apply. Only my supervisors and I will read the notes or transcript of the interview. The interview transcripts, summaries and any audio recordings will be kept securely and destroyed 2 years after the research ends.

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study before May 30<sup>th</sup> 2017;
- ask any questions about the study at any time;
- receive a copy of your interview recording;
- read over and comment on a written summary of your interview;
- agree on another name for me to use rather than your real name;
- be able to read any reports of this research by emailing the researcher to request a copy.

If you find any of the questions in the interview generate distress for you during, or after the interview, there is a list of potential help and counselling services provided at the bottom of this information sheet. Whilst all efforts have been made to make this process comfortable, I

acknowledge the emotional nature of this topic, and my limitations as an outsider in understanding how some questions may impact you.

If you have any questions, either now or in the future, please feel free to contact either:

**Student:**

Name: Jaime Flack

University email address:

**Supervisor:**

Name: Fiona Hutton

Role: Senior Lecturer

School: School of Social and Cultural Studies

Phone:

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email or telephone

**Help/Counselling services**

Alcohol Drug Help Line 0800 787 797

Life Line 0800 543 354

Health Line 0800 611 116

Samaritans 0800 726 666

## Appendix I: Ethics Approval- Original Study



Phone  
Email

### MEMORANDUM

TO	Jaime Flack
COPY TO	Dr Fiona Hutton
FROM	AProf Susan Corbett, Convener, Human Ethics Committee
DATE	2 October 2016
PAGES	1
SUBJECT	<b>Ethics Approval: 23532</b> Liquid Handcuffs(?): The female experience of Opioid Substitution treatment in New Zealand.

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 31 July 2018. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards

Susan Corbett  
Convener, Victoria University Human Ethics Committee



## Appendix K: Participant Consent Form- Current Study



### A gendered difference: The female experience of Drug and Alcohol Treatment in New Zealand.

#### CONSENT TO INTERVIEW

This consent form will be held for 2 years.

Researcher: Jaime Flack, School of Social and Cultural Studies, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part in an audio recorded interview.

I understand that:

- I may withdraw from this study at any point before May 30<sup>th</sup> 2017 and any information that I have provided will be returned to me or destroyed.
- The information I have provided will be destroyed 2 years after the research is finished.
- Any information I provide will be kept confidential to the researcher and the supervisor. I understand that the results will be used for a Masters report and a summary of the results may be used in academic reports and/or presented at conferences.
- My name will not be used in reports, nor will any information that would identify me.
- I would like a copy of the transcript of my interview: Yes ☐ No ☐
- I would like a summary of my interview: Yes ☐ No ☐
- I would like to receive a copy of the final report and have added my email address below. Yes ☐ No ☐

Signature of participant: \_\_\_\_\_

Name of participant: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix L: Participant Information Sheet- Current Study



### **A gendered difference: The female experience of drug and alcohol treatment in New Zealand**

#### **INFORMATION SHEET FOR PARTICIPANTS**

Thank you for your interest in this project. My name is Jaime Flack and I am a Masters student in Criminology at Victoria University of Wellington. This research project is work towards my thesis, and may be used in academic publications and conferences.

#### **What is the aim of the project?**

This project aims to examine the experiences of New Zealand women who have received drug and alcohol treatment. The Victoria University of Wellington Human Ethics Committee have approved this research.

#### **How can you help?**

If you agree to take part, I will interview you at a time and place of your choice. The length of the interview is not expected to exceed 1.5 hours. Interviews will be recorded using a digital recorder to minimise the need for notetaking during the interview. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before May 30<sup>th</sup> 2017. If you withdraw, the information you provided will be destroyed.

This research is confidential. You will be given a pseudonym (fake name) to protect your identity and privacy. However, if you do disclose a risk of self-harm, or harm to others, confidentiality may no longer apply. Only my supervisors and I will read the notes or transcript of the interview. The interview transcripts, summaries and any audio recordings will be kept securely and destroyed 2 years after the research ends.

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study before May 30<sup>th</sup> 2017;
- ask any questions about the study at any time;
- receive a copy of your interview recording;
- read over and comment on a written summary of your interview;
- agree on another name for me to use rather than your real name;
- be able to read any reports of this research by emailing the researcher to request a copy.

If you find any of the questions in the interview generate distress for you during, or after the interview, there is a list of potential help and counselling services provided at the bottom of this information sheet. Whilst all efforts have been made to make this process comfortable, I



acknowledge the emotional nature of this topic, and my limitations as an outsider in understanding how some questions may impact you.

If you have any questions, either now or in the future, please feel free to contact either:

**Student:**

Name: Jaime Flack

University email address:

**Supervisor:**

Name: Fiona Hutton

Role: Senior Lecturer

School: School of Social and Cultural Studies

Phone:

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email or telephone

**Help/Counselling services**

Alcohol Drug Help Line 0800 787 797

Life Line 0800 543 354

Health Line 0800 611 116

Samaritans 0800 726 666

## Appendix M: Ethics Amendment- Current Study



Phone

Email

### MEMORANDUM

TO	Jaime Flack
COPY TO	Fiona Hutton
FROM	AProf Susan Corbett, Convener, Human Ethics Committee
DATE	13 March 2017
PAGES	1
SUBJECT	<b>Ethics Approval: 23532</b> A Gendered Difference: The female experience of Drug and Alcohol Treatment in New Zealand.

Thank you for your request to amend your ethics approval. This has now been considered and the request granted.

Your application has approval until 31 July 2018. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards

Susan Corbett  
Convener, Victoria University Human Ethics Committee

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