Research Paper
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A Woman's Place?
Identifying the Needs of Female Drug Users and Responses in Drug Treatment Policy and Practice

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This Be The Verse.

They fuck you up, your mum and dad.

They may not mean to, but they do.

They fill you with the faults they had

And add some extra, just for you.

But they were fucked up in their turn

By fools in old-style hats and coats,

Who half the time were soppy-stern

And half at one another's throats.

Man hands on misery to man.

It deepens like a coastal shelf.

Get out as early as you can,

And don't have any kids yourself.

Larkin P. (1974) *High Windows.* New York: Farra, Strauss & Giroux

Introduction

The author's background is in social care, she has had 20 years of experience as a practitioner and manager, encompassing areas of disadvantage that include disabilities, offending and substance misuse. The interest in this research stemmed from her work as manager of the Drug Interventions Programme (DIP) in Hull, where she noted that female drug users were generally reluctant to engage with services, although those who did engage were largely successful in completing an agreed care-plan, which led them to be either stable in treatment, or abstinent.

The approach to this research is qualitative. The original purpose of the research was to attempt to establish why some women engage well with services and achieve their care-plan goals, whilst many others recognise that they need intervention and treatment, but refuse to engage with it.

The initial aim was to identify any variance in need or motivation between women who engage with services and those who refuse, and any specific barriers. However, two major factors emerged during the interview phase, and these re-directed the research. The women described high levels of disrupted attachment and the prevalence of complex, multiple needs or 'poly-problems'. The main questions that evolved from this were, 'What are the real underlying causes of female drug use?' and 'Does the treatment system recognise them and make adequate provision for women?'

The first main chapter of this paper looks at the myths of addiction, societal perceptions and motivation. It introduces the concepts of attachment and 'poly-problems'.

In the second chapter attachment theory is applied to the empirical data, to give the reader an insight into the lives of the research cohort.

'Poly-problems/mono-solutions' the third major chapter, examines the complex needs demonstrated by the research cohort, and considers the likely effectiveness of the current national drug strategy, and the resulting operational delivery in meeting these needs.

Methodology

Consultations with a 'key informant' a woman in her mid-forties who is a former drug user, informed the process. She is very active in the local user involvement group and acts as an adviser to the National Treatment Agency. This informant advised on the key issues for female drug users and assisted in the design of the interview questions, finally acting a pseudo-interviewee as a trial of the full interview process.

Flyers were used to advertise the project in the DIP office, treatment agencies and main needle exchange in Hull city centre. Workers also raised awareness of the research when speaking to female clients. The women who took part in the research all volunteered, they were not selected for any particular demographic or personal reason. All of the women who volunteered were interviewed.

The original intention was to interview 10 women who were engaging in treatment and 10 who refused to engage. The ten women in treatment were interviewed first, followed by five women who volunteered via the needle exchange. At this point, the author had collected a large amount of data and the law of diminishing returns had begun to apply. As a result, it was decided to end the interview phase.

In order to establish consent, at the beginning of each interview the researcher explained the purpose of the research, gave an assurance that all participants would remain anonymous and clarified that the women could refuse to answer any of the questions,

if they so wished. A written sheet was provided giving an outline of the key points about the research. If the woman consented and wished to continue with the interview at this point, she was asked permission to tape the interview, so her responses could be accurately captured. If the woman did not wish to participate further, she was thanked and the conversation was terminated. Only two women declined the interview, when the purpose had been explained.

A semi structured interview technique, asking six open questions was used.

This section also outlines the quantitative data that was collected prior to the interviews, via a written questionnaire.

The use of pseudonyms throughout the report protects anonymity. Where case studies are used these may be composites, but they accurately reflect the women's narrative.

In the course of the interviews, many of the women disclosed personal and sometimes distressing information. The interviewer, as a qualified practitioner and counsellor, offered time at the end of the interview to ensure that each woman returned to an emotionally 'safe' state before leaving.

General demographic data:

There were no notable demographic differences between the women in treatment and those who were not accessing treatment.

The age range of the women interviewed was twenty to sixty two years (average age 35.6 years).

Four of the women were single with no partner, nine were married or living with partner, one was divorced and one widowed.

Five of the women had no children at the time of being interviewed, four had children living with them and a further four had children being cared for elsewhere. Two of the women had children over the age of eighteen, who were living independently.

Four women lived in their own tenancies and six lived with a partner in his/her tenancy, one woman lived with family members, three in hostel accommodation and one was a homeowner.

None of the women was currently employed, but ten had been in paid employment at some time in their lives.

Substance misuse:

Fourteen of the women interviewed started their drug use with cannabis, the age range for cannabis use was twelve to twenty five years (average age for starting cannabis use 14.7 years).

Thirteen of the women who began using cannabis went on to use heroin, the age range for heroin use was fifteen to forty years (average age at initiation 23.2 years).

In this same group of women, ten also commenced cocaine use, the age range for this being seventeen to twenty five years, (average age at commencement 23.4 years).

Other drugs used include amphetamine, illicit methadone, illicit subutex, illicit diazepam, sleeping tablets, ketamine, psyllocybin, yahuasca, san pedro cactus and salvia divinorum and alcohol.

Injecting practices:

The women were asked about injecting heroin, since this is the predominant drug of choice and route of administration in Hull. Of the group who were in treatment six (60%) had injected heroin at some time and three (30%) were still injecting, on top of their substitute prescribing. Within the 'not in treatment' group three (60%) had injected heroin at some time and two (40%) were still doing so.

Substitute prescribing:

Of the ten women in treatment, eight had used heroin at some point in their drug-using career and seven were currently receiving substitute prescribing, although three of these were continuing to inject heroin on top.

The Myths of Addiction

Why do people use illicit substances?

The broad question of why people, both male and female, use illicit substances is one that has an important part to play in this research, because an understanding of the underlying reasons for substance misuse helps to inform the development of motivation for desistance.

Addiction theory, developed within a medical model of substance misuse has two basic flaws: firstly, the addiction syndrome (craving, dependence and tolerance) cannot exist at the initiation stage of drug use and in most cases does not exist until a significant period of use has elapsed. Secondly, the theory cannot apply to the use of cocaine and its derivatives, since these substances do not create a physical dependence. There is some belief that psychological dependence can occur after a period of use, although the evidence is not conclusive.

Peer pressure is also identified, usually as the reason for initiation, if not for continued use, but Jay (2007) suggests that this does not sit comfortably with the fact that experimental teenage drug users in his research demonstrated higher than average levels of self-esteem, he claims that this renders them less likely to respond to peer pressure. However, adolescents can be influenced by parents to make advantageous peer selection decisions, which may affect their adult life decisions. Kerns and Contreras (2000:173,174) examined parental influence on adolescent peer decision, they found:

> 37 percent of mothers reported that they try to keep their children from being influenced by peers by talking to them

about future consequences of their behaviour. Other strategies include spending time with their children (14 percent), giving their opinions about their peers (10 percent), and doing nothing in particular (10 percent). Several other responses were reported by parents with less frequency, including having the child invite “desirable” friends to the house (6 percent), limiting interaction with particular children who may negatively affect the adolescent (6 percent), encouraging activity with “desirable” peers (2 percent) and praising the child (2 percent).

It appears that parents, and in particular mothers, who are firmly attached to their children, use a range of strategies to guide adolescent peer decisions and as a result have a direct influence on the range of behaviour decisions the adolescent, and subsequently the adult, will make.

Jay (2007:2) raises a subject seldom considered in drugs work or policy development – pleasure. He says ‘It is pleasure which is the defining quality of all illicit drugs: those drugs which are abused have pleasurable effects, and those which have no pleasurable effects are not abused’. He explores the pleasure theory as the genuine reward to drug users, speaking of pleasure he notes ‘And may we also conclude that its presence in the debate, though unspoken, remains powerful: pleasure is, for example, perhaps the most significant distinction between heroin and methadone maintenance’.

Other research shows that many factors play a part in both male and female drug use. Social, economic and emotional factors

impact on the drug using decisions of both males and females, and these are likely to vary according to gender. (Klee 2002, Becker & Duffy 2002, Neale 2004, Payne 2007).

Women in society:

Whilst a woman's place may no longer be described as 'in the home', the socially constructed gender expectations of women as carers, nurturers, homemakers, and those with responsibility for maintenance of the social codes seem to be accepted by the majority. A common theme across a range of cultures tasks women with family responsibility and moral guardianship, whilst allowing men a degree of tolerance and greater freedom. The female role, in this sense, is somewhat reinforced, in respect of attachment. In this construct, the woman is central to the notion of a 'secure place' in the home and family, firmly attached emotionally and economically.

MacDonald (1994) examines the woman's role in numerous and varying cultures, including Russia and The Sudan and finds a commonality of ascribed female roles and acceptance of male substance use, for the most part excessive alcohol use. In the Scottish highlands, she observes that heavy drinking is an accepted norm for men. However, the standards applied to women differ considerably 'The stereotype of the drunken male highlander is that of an amiable, affable buffoon. A drunken woman however, is quite a different story: she is undoubtedly unrespectable, slovenly and loose, always a despicable or pathetic rather than humorous figure' (MacDonald 1994:129).

Ettorre (1992:37) quotes Youcha 1978 'Regardless of whether or not women drink, all women share the same cultural commandment to be the guardians of moral and social values'.

In recent years it has appeared that some women, particularly in the younger age groups in Britain are resisting conformity to this social norm in the rise of what is termed by the media 'ladette culture' – a combination of binge drinking and violent behaviour. A total of 88,139 women were arrested for violence against the person in 2008, an increase from 87,140 in the previous year, alcohol is blamed for approximately half of this offending. Elaine Arnull (South Bank University, London) describes a 'link between girls using alcohol and violence.'

In response to the increase in female drinking and related violence The Home Office are to launch a series of advertisements in June 2009, primarily aimed at women aged 18 to 24. The advertisements will be printed, on radio, on YouTube and in a series of spin-off episodes of the Hollyoaks series. There is apparently no parallel advertising aimed at young men.

Whilst some women in Britain may be choosing to disregard gender inequality in respect of socially acceptable behaviour, it appears that the present government is firmly committed to reinforcing it.

Victimisation or agency?

Does this 'cultural commandment' extend from alcohol misuse to another dominant social issue – illicit drug use?

According to Eaton (1993), it continues to apply: 'Traditional gender divisions prioritize the domestic role in women's lives and marginalize all others. Furthermore, this domestic role is constructed in relation to a male provider'. (Eaton 1993:92).

This is more strongly expressed by Ettorre (1992.10), in describing society's view of female heroin users, she says 'A substance abusing woman is the quintessence of a wicked woman defiling her body with harmful substances'. 'They are perceived as sicker and more deviant than their male counterparts……………… In effect women heroin users are polluted women par excellence' (Ettorre 1992:76).

In Britain society frequently perceives female drug users as passive victims of male dominance and coercion (Home Office 2007B). Payne (2007) however, describes a number of women in her study in North Cumbria who were actively involved in the decision to initiate their heroin use. Many of the women in Payne's research had male partners who were injecting drug users and this increased both their desire to try the drug and its availability. These women gained access to heroin through a male partner, they seemed to be attracted to that partner by his heroin addiction, and to envy the experience. Often the partner disapproved and attempted to discourage the woman from heroin use.

Some initiated use through other routes. Describing the experience of one woman '…..she explains that emulating a self-confident friend, whom she had watched using heroin, was a critical influence'. 'The stereotype of passive women pressurised into using

drugs by their partners is undermined by women who report taking an active role in their initiation into drug use and injecting, sometimes despite their partner's unwillingness or disapproval'. (Klee 2002:17)

Despite the social construct of women as moral guardians, and the secure attachment this role offers, it must be conceded that some women refuse this ascribed status and choose to engage in behaviours, including offending, alcohol and substance misuse, regardless of the prevailing societal norms.

Attachment:

Many psychologists believe that emotional security depends upon connections with other people, which they describe as attachment, a theory that underpins a large body of modern psychotherapy. They suggest that the attachment formed between parents and infant, particularly between mother and infant is crucial. The security or disruption of attachment in infancy will later affect the adult's ability to relate to others – siblings, partners, offspring and even therapists.

Bowlby (1998) primarily examined attachment theory by focussing on the attachment between mothers and infants, however he noted that attachment was not confined to children, 'Although usually less readily aroused, we see it also in adolescents and adults

of both sexes whenever they are anxious or under stress' (Bowlby 1998:6).

Bowlby (1998:12) discusses the key concept of a 'secure base':

> 'This brings me to a central feature of my concept of parenting – the provision by both parents of a secure base from which a child or an adolescent can make sorties into the outside world and from which he can return knowing for sure that he will be welcomed when he gets there…………'. (*Bowlby describes the child as 'he' but intends the description to apply to either gender).*

He goes on to consider both secure and disrupted attachment in infancy and some of the effects of disrupted attachment, which can affect adult behaviour. Bowlby also makes a link to child abuse and to women who are abused by a male partner, 'no one with eyes to see can any longer doubt that all too many children are battered by their parents, either verbally or physically or both, nor that all too many women are battered by a husband or boyfriend.' (Bowlby 1998:88).

He speculates that maternal interaction during childhood is likely to have the greatest influence, particularly on female children:

> 'As yet too little is known about how the influence on personality development of interactions with mother compared with the influence of those with the father. It would hardly be surprising were different facets of personality, manifest in different situations, to be influenced differently. In addition

> their respective influence on males may be expected to differ from their respective influence on females………….. Meanwhile it seems likely that, at least during the early years of an individual's life, the model of self interacting with mother is the more influential of the two.' (Bowlby 1998:145).

Again, Holmes (2001:5) concurs: 'In traditional societies the secure base is provided by the family and tribal group, with a hierarchy of available care-givers, although interestingly, the mother is almost always at the top of the ladder.'

The emotional learning process is thought to generalise from family to relationships outside of the family circle and arguably from childhood to adulthood. So people who suffer poor maternal attachment are likely to have less rewarding relationships outside of the family, leading to subsequent vulnerabilities:

> 'Children develop emotion regulation styles largely within parent-child relationships. These modes of dealing with emotions in inter-personal relationships are thought to generalize to other interpersonal contexts, such as relationships with peers, and therefore to influence the quality of children's relationships outside the family. (Kerns and Contreras 2000:1)'.

Noting the relevance of attachment in adulthood Frey (2006:304) studied the attachment relationships of American college students. She observed an influential gender difference, '….college women reported greater parental attachment than men and …. this

greater attachment was significantly associated with higher social competence and psychological well-being for women.'

Holmes describes acts of 'self-soothing' as a natural response to disrupted attachment. The nature of self-soothing can be harmless, for example, a long hot bath or a massage. It may be harmful, as in the case of deliberate self-injury, which then elicits a soothing response from a medical professional. It also has a clear link to substance misuse 'The inappropriate use of alcohol and drugs similarly blots out pain physiologically, and provides a feeling of being held and divested of responsibility similar to that which is sought when attachment needs are activated and assuaged.' Holmes (2001: 100).

Similarly Ansbro (2008:239) considering the links between disrupted attachment and offending behaviour, finds that drug use is one method that offenders may choose to, in her term, regain equilibrium. 'A dismissing style of attachment, with its typical detachment from emotion and thought, is likely to fast forward the individual straight into a behavioural, sometimes violent response, or short cuts will be found to regain equilibrium – alcohol, drugs, violence, sexually abusive acts.'

The therapeutic alliance between a therapist or drugs worker and a client represents a form of attachment. Bowlby considers the impact of disrupted attachment in therapy and discusses the degree of transference that might be experienced by the therapist, as a result, whilst Holmes (2001:4) says 'Therapists aim to create some of the parameters of secure base in their dealings with patients:

consistency, reliability, responsiveness, non-possessive-warmth, firm boundaries.'

Ansbro (2008:241) advocates that Offender Managers recognise and utilise the offender's need for attachment, as an adjunct to the widely used cognitive behavioural approaches. 'Attachment theory elaborates on the cognitive behavioural framework; it helps us speculate about what experiences might have led to such deficits, to appreciate them as deeply rooted rather than mere gaps in learning, and to understand how workers in the Probation Service can provide a taste of a secure base.'

Attachment, relationships, substance misuse and the therapeutic alliance were clearly emerging themes from interviews conducted with female drug users in Hull. Women who had suffered disrupted attachment in childhood made peer and lifestyle decisions that led them to present to services with a series of multiple and complex problems, or worse, to avoid engagement with services because of the overwhelming nature of these problems.

'Poly-problems':

Returning for a moment to problem drinking as comparable to illicit drug use, Ettorre (1992:37) raises the hypothesis of 'polyproblems' which she says are a major barrier 'In effect women problem drinkers experience a variety of problems of living, or what Murphy and Rosenbaum (1987) refer to as "polyproblems". These "polyproblems" do not allow women problem drinkers to fit comfortably within society or the treatment system.'

This phenomenon also applies to female drug users, factors including poverty, deprivation, poor educational attainment, low self esteem and unresolved childhood issues, medical or psychological problems, as well as the previously discussed male influences, are thought to be possible catalysts for female drug use (Klee 2002:19). 'Given the nature of some women's earlier histories…………perhaps it is not surprising that many women seeking drug treatment have multiple complex inter-related problems which require attention…' (Klee 2002:20).

The evidence suggests that whilst there are also identifiable contributing factors in male drug use, the factors are gender specific. 'Although it is common to use gender-neutral language to describe addiction, there is evidence that the experience of addiction and its contributing factors are different for women than for men.' (Whynot 1998:335).

Becker and Duffy (2002:16) describe some of the factors significantly affecting female drug users, 'Women drug users have a high incidence of past traumatic experiences, such as sexual abuse, domestic violence, death of a child or a stillbirth (Broom 1994). Some estimates suggest that as many as seventy percent of women in contact with treatment services are survivors of sexual or other assault, particularly in childhood.'

Corston (Home Office 2007B: 61) also clearly identifies a list of complex problems experienced by women. Although she does not refer to men, the implication seems to be that these complex problems affect men less severely.

'During my review a number of people made the point that the problems besetting women, whether or not they are offenders are much the same – they are victims; they have relationship problems; accommodation difficulties; poor mental health; lack of self esteem; and drug or alcohol addictions.'

Children and childcare are frequently raised issues, although not all female drug users are mothers and even fewer are primary care-givers for their children. Where they are primary care-givers, there is an understandable anxiety that engagement with treatment will result in their children coming to the attention of Children and Young People's Services. Fear of professional intervention in children's welfare and a lack of childcare provision is a barrier to drug using mothers accessing treatment services. (Eaton 1993, Klee 2002).

Social stigma is also a greater issue for women. They are reluctant to acknowledge a drug problem to family and friends and generally receive less support from their families than do men. Women are more likely to have a drug-using partner, and may be dependent upon the male for economic and emotional support. 'One consequence of the social stigma of female drug use is that women are more restricted in their choice of sexual partners. In contrast to men who are more likely to be single or to have a non-drug using partner.' (Klee 2002:20).

Shiner (1995) in a study of homeless men and their take up of primary healthcare found that stigma plays a major part in the decision to take up or reject services. The decision is he says a

cost/benefit analysis on the part of the individual, perceived stigmatisation within services raises the cost and reduces the benefit, ‘Respondents who had slept rough emphasised how such an experience changed their relationship with mainstream health services. Such services were viewed as sources of stigma rather than sources of help by respondents whilst they slept rough.’ (Shiner 1995:541).

McGauley (2002:33) in her Rotherham study, found that barriers stemmed from the women’s perceptions of drug treatment services, the services were perceived to be male oriented and not likely to meet the full range of needs of the women. They were poorly advertised and women were reluctant to trust the confidentiality policies. The research did not result in any recommendations where the women unanimously agreed, or attained a majority agreement. The greatest emphasis was on appropriate staffing, but again there was divided opinion about the need for female workers, and some women preferred a named male key worker, who met their needs fully.

Motivation and Desistance:

In examining desistance from illicit drug use, the Liverpool Desistance Study Maruna (2000) made no gender distinctions, but found that:

> ‘The long-term persistent offenders in this sample generally said that they are sick of offending, sick of prison, and sick of their position in life. …….they said that they feel powerless to change their

> behaviour because of drug dependency, poverty, lack of education or skills, or societal prejudice.' (Maruna 2000.74).

Assuming that at least a proportion of female drug users will share the experiences described by Maruna, there is a need to consider how service delivery can motivate and empower women to make lifestyle changes.

Miller and Rollnick (2002) on motivation and substance misuse, state that for many people a natural change, or 'spontaneous remission' will bring and end to drug or alcohol misuse. However, even a relatively brief intervention under certain conditions can trigger change. Longer periods of intervention do not automatically yield a better outcome and the belief of the individual and of the worker or therapist in successful change are critical.

Griffin and Tyrrell (2005:165) express this hypothesis with greater emphasis on self determination, 'You have to want to cure yourself. Effective therapists can build on your motivation and help you learn the skills that others have used successfully to beat addictions…………………….. but they absolutely cannot get rid of addiction for you'.

If self-cure is indeed the route to beating addiction, then the policy-makers and the commissioners of treatment need to begin to consider what services will be effective, in the long term. The current notion of viewing substitute prescribing as a solution to substance misuse, needs to be replaced by a range of interventions that will support the addicted individual to build up the motivation to desist

and the skills to overcome their addiction. Drug treatment services need to recognise and respond to the fact that women have a unique set of factors contributing to their drug use, in order to facilitate change.

Attachment and Disruption

Research findings:

In the Hull research I began the semi-structured interviews with an open question, 'tell me what has happened in your life, to bring you to this point?' Many women told explicit life stories, referring to relationships with their mother and in some cases father and siblings. Bowlby 1998, previously cited, outlined the crucial nature of a secure base in childhood, the narratives indicated that these women had not had positive experiences. They spoke about being in the 'looked-after' system, or left in the care of members of their extended family. A number described childhood abuse and abusive relationships in their adult years. Those who had offspring also talked about those relationships. It quickly became apparent that attachment was a key factor in most cases, in the decision to commence, continue and sometimes re-commence the use of illicit drugs.

Maternal attachment:

One of the most striking features of the research was the way that the women described their relationship with their mothers. Only two of the fifteen women interviewed had a working relationship with their mother, and interestingly, these two were mother and daughter, both of whom were heroin users. Within that family group, the mother had started smoking heroin with her husband, and continued to do so after his death. She expressed concern that both of her daughters injected heroin, she viewed this as far more serious and harmful drug use than her own. One of her daughters, who also took part in the research, considered that she had had a good

relationship with both parents. She had married and become pregnant at the age of sixteen. She went on to describe significant pressure from her mother to continue to live near the family home, and felt that this contributed to her continued substance misuse, since it was part of the culture of the family. None of the three drug users in this family is, or has ever been in treatment.

The remaining thirteen women in the research cohort said they did not have a good relationship with their mother. The degree of this varied, in some cases the mother left whilst her daughter was young: *Louise:* 'Me Mam left when we was young and left six children with me Dad' and *Amy:* 'My Mum and Dad split up, and I was living with my Dad. I didn't see my Mum again.' In other cases, the mother was the perpetrator of abuse or the daughter perceived that her mother had been aware of the abuse but had failed to intervene, and this led to total negation of the attachment: *Gemma:* 'I tell people she's dead. I wish she was I hate the fucking bitch', and *Lauren:* 'I don't have a mother as far as I am concerned. She allowed me to get beat up when I was little. I once screamed out to her for help and she told me she hated me 'cos I were the double of me Dad.' Others described mothers who were alcoholics, had mental health problems and who neglected their daughters for the sake of a sexual relationship or a sexually promiscuous lifestyle.

Of the thirteen women who did not enjoy a secure relationship with their mother, seven said that their mother had abandoned them in childhood, often after a period of abuse.

- *Sue* was introduced to her 'real Dad' at age 11, having never known of his existence until then, her mother said she was sick of being responsible for her and sent her to live with her biological father, in another geographical area. He subsequently abused her and she was taken into the care of the local authority.
- *Kayleigh* stated that her mother was an alcoholic, who also used cannabis and lived a sexually promiscuous lifestyle 'she had a lot of men, really a lot, anything from the postman, to the window cleaner, the butcher and the local alcoholics', eventually her mother moved to another area when the client was 15 and left her with an 'uncle'.
- *Louise*'s mother left six small children, with their father. He met another partner who had five children of her own. The family split up and *Louise* was sent to live with her older brother's parents-in-law, whom she had never previously met.
- *Amy* lived with her father, who introduced her to alcohol and drugs as well as sexually abusing her. She said he gave her the drugs to keep her quiet.
- *Lauren* was taken into local authority care after alleged repeated rapes perpetrated by her stepfather and her brothers.
- *Janet* went to live with her grandmother and uncle when her mother formed a new relationship.
- *Mandy* was taken into local authority care after suffering racial and sexual abuse at the hands of her mother's new partner.

The remaining six women lived with their mothers during childhood. Two reported that their mother had serious mental health problems and they assumed in the role of carer. One remained with her parents but stated they were 'into wife swapping with their niece and nephew' and she was involved in sexual abuse during this time but was unable to talk about it during the interview; one woman remained with her mother and stepfather but suffered a catalogue of physical, emotional and sexual abuse throughout her childhood. Two other women stated that they did not really get on with their mothers but gave no specific reasons.

Paternal influence:

Of these thirteen women, two were abandoned by their mother and left with their father, although neither described a close and successful relationship with him. Five described abandonment by their father at an early age and having no further contact. Two women described fathers who were physically abusive to their mother and two gave no information at all. One woman stated she did not get on with either parent. One woman in the research cohort had a close relationship with her father, but not with her mother. Her comments suggested an incestuous relationship with her father, but this had led her to enjoy a privileged position in the family, which she expressed in positive terms.

Siblings, attachment and abuse:

Ten of the fifteen women interviewed had siblings, either full brothers and sisters or half-siblings raised in the same household,

only one reported having a good relationship with her sister. The other five women had no siblings, or did not provide the data.

Five of the women reported acting as carer for their siblings, though they were very young themselves. Some examples of their experiences are:

- *Kayleigh:* 'I did what my Mum should have been doing, I looked after my brother, I was 15 and he was 7. I did all the cleaning and cooking. Taking heroin was like relaxation at the end of the day.'
- *Gemma:* 'My mother had three kids with her second husband. I had to look after them and do all the shopping, cooking and cleaning. I was only 11. If everything was not how she wanted she'd kick hell out of me. I once accidentally dropped and broke the iron and she fractured my skull for that.'
- *Rosie:* 'There were 7 of us and the youngest (*name*) is 12 years younger than me. I had to have him in my room and look after him all the time, my Mam was always out drinking.'

Two women alleged abuse by their siblings. One woman said that, with her mother's knowledge, her stepfather and three brothers regularly raped her. Her mother declined to intervene. The second, *Anna,* reported a cycle of sibling abuse; her elder brother seriously, physically abused her and later she became the perpetrator of physical abuse toward her younger brother. This continued until the younger brother retaliated at the age of 15. The mother of this family

did not intervene at any point, although she was fully aware of the abuse.

Other significant adults:

Three of the women had lived with grandparents or a grandmother for a time and seemed to have formed a secure attachment in those relationships.

Beth, whose mother suffered serious mental health problems, moved back to Hull to live with her grandmother at the age of seven. Her grandmother acted as carer for her mother for four years, until her grandmother died. After this *Beth*, then aged eleven, had to take on the role of carer, hiding the issues from teachers and social services, to allay her mother's paranoia.

Janet said her mother, a drug dealer who has been imprisoned numerous times, had never shown her any love and had sent her to live with her grandmother and uncle. In this relationship, the grandmother had provided a reasonably secure base but had been overly keen to pursue her granddaughter's musical talent, which *Janet* had not wanted to do.

Gemma lived with her maternal grandparents up to the age of six. Her grandmother acted in a nurturing role, for example taking her on outings and to school. Grandmother had also acted as carer to *Gemma's* mother, a role later ascribed to *Gemma,* then aged seven, when the family left the grandparents' home.

Sue was the only women to refer to another significant adult. She ran away from home at the age of twelve, with a woman for whom she used to baby-sit. The woman was a drug dealer and her

own children had been taken into the care of the local authority. This event had followed a physical assault at home: ‘I had been told to stay in my room, but I needed to wee so badly that I went downstairs to the toilet. She (*Sue’s mother)* was on her back on the floor with Jason on top of her with his willy out. She chased me back up the stairs and kicked the fuck out of me.’ *Sue* was ultimately found and returned to the family home.

It is noteworthy that only four of the women in the research cohort mentioned any significant adults, other than their parents, when the norm in most functional families is to have some level of contact with the extended family and/or a network of friends and acquaintances.

Adult relationships:

The research cohort predominantly had poor relationships with parents and only a few had another significant adult in their lives. Some reported acting as carer for younger siblings, or for their mother and several had experienced abandonment, leading to local authority care. A number of them had also experienced physical, emotional and sexual abuse in childhood. It is reasonable to assume that in terms of attachment theory, they are unlikely to have established a secure base from which to approach the adult world. This section continues to examine the data, following the progress of the women into their adult relationships.

Only one of the women, aged 20, did not mention any adult relationships. Another woman described two lesbian relationships, although the fact that she has two children who pre-date these

suggests that she had a relationship with a male partner previously, although she declined to discuss it. Both of the lesbian relationships have been troubled and abusive, she describes the current relationship as 'rocky'.

The remaining thirteen women had a relationship with a male partner at a relatively early age, often describing these as abusive. Eleven of the women commenced Class A drug use in the course of this first relationship, or shortly afterwards.

Some of the comments suggest that the women were once more searching for a secure base, within these relationships: 'I got married to get away from my mother. I just wanted to be loved, but my husband was as bad as her, and they were both at me, in different ways.' These women began adult relationships without the benefit of a secure childhood base. They were quickly attracted into relationships that were frequently abusive, sometimes linked with pregnancy at an early age, and ultimately lead to their initiation into illicit drug use. This pattern was recognised by Bowlby (1998:105) as he examined the plight of women who had been physically abused by male partners '………. many of the wives who are battered come from disturbed and rejecting homes, in which a significant minority were themselves battered as children. These experiences had led them to leave home in their teens, to link up with almost the first man they met, all too often from a similar background, and quickly to become pregnant.'

Women who did not begin their drug use with a partner also made statements that suggest a search for attachment: 'I started

(*using Class A drugs*) at a young age through being with a group of older people who used. You want to be accepted as part of that group, so you just do it.' A second woman said 'I met other women who did it (*cocaine*) as well, it was the first time I had friends and was part of a group.'

In spite of this, all of the women believed that they had exercised choice about whether or not to use illicit drugs. Some examples of their initiation into drug use are:

- *Sue:* 'I came out of the care home when I was 16, and I met this bloke, he was a drug dealer – he just cared for me. Then he started beating me………'
- *Louise:* 'I went out with a boy when I was 16 and got pregnant, first shot. It was an Irish family, the mother didn't like me. I had my second child when I was 17 and they threw me out and took my children to Ireland. That's when I started using the amphetamine……….'
- *Beth:* 'When I was 20 I moved to London and met the man who was to be my partner of five years. He was 16 years older than me, an ex-heroin addict. He relapsed and it got me down, so I started using too. I didn't want to leave him; it kind of gave us something in common.'
- *Lauren:* ' I started using with my mates during the day. It took the pain away. I was about 22 at the time.'
- *Liz:* 'I met this lad who had a lot of money and didn't need to work. He had a lot of cocaine, so we'd go out clubbing and do cocaine and ketamine.'

- *Mandy:* 'I was with a partner, he encouraged me to try heroin. I didn't know what it was.'

Many of the women demonstrated a pattern of maintaining abstinence whilst in a reasonably stable relationship, but lapsing into substance misuse as the relationship came under threat or broke down, perhaps using the substances as a method of 'self-soothing' (Holmes 2001) or as a substitute attachment as their secure base became more disorganised.

Lauren is currently engaged in sex work and smokes heroin, cannabis and crack cocaine. She describes periods of substance misuse and abstinence, alongside major life events:

> 'I was a teenage runaway at thirteen, because of my step-father and brothers raping me all the time. I ended up with people who were a lot older than me, to stay hidden from the police. I started smoking dope with them. I'd go to people's houses and they'd be smoking so I'd smoke with them. I knew if I went back home the rapes would start again.
>
> I got a job and lived in a flat in London, I wasn't using any drugs then, I had mates and we had a good time. I started using heroin after some surgery when I was 21 or 22. I had my first daughter in (*date*) she's Downs Syndrome, I needed to get clean to be able to look after her so I went into drugs rehab. I only lasted 8 weeks because I missed her so much, but I lost her completely.

Then I went back to London for 18 years, I got back with the partner I was in love with years ago and I didn't use heroin at all in that time, not at all. Maybe just a bit of crack, recreational like.

Then we made the mistake of moving back to Hull, she was commuting to London all the time, the relationship broke down and I went back to the drug use. It has ruined my life, I've lost everything, my home, all my furniture, my eldest daughter is in a care home and won't have anything to do with me, they've poisoned her against me. My youngest daughter is now my "son" and he follows everything I do, it's like a pattern. It in't good. I don't like it.'

Rosie started to use heroin after a painful divorce:

'I was married for two and a half years and had two miscarriages, I can't ever have kids – that's when I turned to drugs. There were a lot of issues, it was a messy divorce, my parents weren't there for me to turn to. I went back to an ex boyfriend who was a heroin user, I didn't want to, but I was insecure, so I went there just to be with someone. I stayed there and let him treat me bad. This kid called (*name*) came round and offered me some heroin, he said it would help me get a good night's sleep. I asked for some more next day. By the time I wanted to stop, it was too late. I was addicted. I used for 6 years, I always managed to fund my habit, I never stole for it.

Finally, I left and went back to (*place*) where my Mum and Dad were living. I was clean there for fourteen months. I shared a flat for eight months with this lovely girl, she was only twenty-

one, she accidentally fell out of the window and died. Then my friend killed himself and that pushed me off the edge and I started using again.

Two and a half years ago, I moved to (*another town*) and met the man who is my partner now. He was a dealer, but he wanted to stop, so we escaped to Hull. We had to run away or he would of been killed and I would of been hurt as well. We have been here six months and we are both in treatment and not using at all.'

Offspring:

Five of the women interviewed said they had no children. Six have sons or daughters who are now adults, four of these women said their offspring had done well in life and were not drug users. There is occasional contact between mother and offspring. One woman, who had smoked heroin for almost 40 years, has two daughters who are injecting heroin users and are not in treatment. She continues to have a close relationship with them, but disapproves of their drug using habits.

Lauren's elder daughter has Downs Syndrome and lives in a care home, she refuses to have any contact with the family. Her younger daughter has serious mental health problems and issues around gender and sexuality. She requires surgery but clinicians require her to desist from substance misuse before they will treat her. *Lauren* expressed a lot of guilt and regret about her offspring, particularly the younger one. She said she had set a bad example as

a parent and felt responsible for the things that had happened to her children.

Four of the women have young children. *Anna,* a stimulant user, is now achieving abstinence. Her two school-aged children live in the family home and are cared for well. *Beth* recently relapsed into heroin use after a period of abstinence. She has a one-year-old baby and is in the early stages of her second

pregnancy. Her partner is drug free and maintains stability in the home. *Beth* expressed strong motivation to desist, citing her partner and children as her main reason for this choice. *Liz* gave up custody of her son, then aged eight, to his father, because of her heroin addiction. She is in a new relationship, with another heroin addict, and the couple have a 2-month-old baby girl. Both parents used heroin throughout the pregnancy, the baby suffered neonatal withdrawal syndrome and is currently in local authority care. Both parents are now in treatment, attending parenting classes and seeking stable accommodation, with a view to having the child returned to them. *Mandy* has a one-month-old baby girl, her first child, who is in foster care with her aunt. *Mandy* is stable in treatment and seeking accommodation so that she can regain custody of her child.

It appears that the majority of the women who had children, had managed to provide them with a secure base and avoid inter-generational drug use, although in two cases this had not been so. The women who had young children all regarded this as a very strong motivator for desistance from drug use, to seek stable

accommodation and generally improve their lifestyle, in order to provide a secure base for their children. It may be possible that having a child has provided a secure attachment for these women, enabling them to make altered lifestyle decisions.

The therapeutic alliance and attachment:

Bowlby (1998) and Holmes (2001) both recognise that the therapeutic alliance between a patient and a therapist represents a form of attachment and that the therapist seeks to embed in the relationship, some facets of a secure attachment.

Nine of the ten women who are in treatment, identified their relationship with their Drug Interventions Programme (DIP) Case Manager as being the key factor in their engagement with the programme. One woman said she would only see her allocated worker, as she could not face telling her life story to anybody else. Others mentioned help, support, warmth and the truthfulness of the therapeutic relationships. Two women particularly valued home visits in the early stages of their engagement saying this had given them confidence. One woman said 'I know she *(the worker)* doesn't judge me, so I have to tell her the truth.' The women who were not engaged in treatment were less convinced of the benefit of a therapeutic alliance, but one said 'What I think would really help is to have a decent relationship with a case worker. And not being turned away when you come to ask for help.'

The women in the research cohort have clearly demonstrated the lack of a secure base and a functional emotional attachment in childhood. They lacked guidance in respect of peer selection, and many developed relationships outside of the family in their early teens that brought them into contact with substance misuse. From this point, they went on to make poorly informed life decisions and apply inadequate problem solving skills. As a result they present with a lifestyle that incorporates multiple and complex problems or 'poly-problems'.

Poly-problems/Mono-solutions

Poly-problems:

Earlier in this paper the concept of multiple and complex problems, or 'poly-problems', was raised as an underlying cause of female substance misuse. Murphy and Rosenbaum (1987), Klee (2002) and Corston (Home Office 2007B) all described a range of problems that were not only causal factors, but also prevented women from fitting into treatment and society, whilst Whynot (1998) suggested that the contributing factors are different for women than for men.

This research has focussed on women and the information obtained from them, so no comment can be made on the contributory factors that pertain to male substance misuse. What is clear, is the degree to which the women who took part in the research experience multiple and complex problems. A hundred percent of the women, in the course of their interview, identified

complex, overlapping and in some cases overwhelming problems that affected their substance misuse and their engagement with services. Many used the word 'pain' in various contexts, to describe their reasons for using illicit drugs, this could be construed as emotional pain, or lack of a secure attachment.

The effects of abuse:

Five of the women said childhood abuse and being in the 'looked-after system' still impacts on them and they would need help, probably counselling to overcome this. Three had suffered repeated and multiple rapes, one woman said her step-father had raped her every night and every morning over a period of years. Another woman, the survivor of racial and sexual abuse perpetrated by her mother's partner said 'Then when I was 15 I had like a nervous breakdown and from there I got took to a children's home and from the children's home to a bed and breakfast. Since then I have been like a survivor for myself.' A third woman said 'I need to get help to overcome my early childhood trauma, that's what I need now.' Another woman explained why she had chosen illicit drug use, almost as though it gave her reason to continue her life: 'The reason why I was doing it, I don't know, cos I was hurting inside…………………with drink you wake up the next day. With drugs you've got to get the money for it, you've got get it whatever, so you have to carry on.'

Six women were still suffering the effects of abuse from a partner or husband and some had repeat patterns of being in an abusive relationship. Some of these women turned to substance misuse to alleviate the pain of the abuse: 'I used (*cocaine*) with me

girlfriends, some of them was in bad relationships as well, so we like calmed our shit down together and tried to get our heads sorted.' Another said 'I started using through this lass called (*name*) I was scared at first, but I tried a bit (*of cocaine*) and I loved it. It made me feel better than I had ever been, like the real person I could be. It's nice, it takes the pain away.'

Mental health problems:

Mental health problems were common, some women were receiving medication for these, but a number said their GP was unsympathetic or blamed their substance misuse for the mental health problems and refused to treat them. They described psychosis, depression, mood swings, agoraphobia, panic attacks, paranoia and anxiety as some of the problems they experienced. One woman said she could not go out of the house during the day, without experiencing severe symptoms of agoraphobia. She went out at night and would keep to quiet streets and avoid groups of people; this prevented her from accessing treatment for her substance misuse, because she could not contemplate a daily visit to a pharmacy for supervised consumption of methadone. This would be the only treatment choice available to her, in Hull.

Many of the women said their illicit drug use helped to alleviate the symptoms of their mental health problems, one referred to the concept of desisting from substance misuse saying 'I never could, I'm in too much pain.' Four of the women reported more than one occasion when they had attempted suicide, one who had overdosed said 'I was in a coma for four weeks afterwards.' Others

had tried a variety of suicidal methods including cutting their wrists and attempted hanging.

Physical ill health:

Several women also described serious health problems including diabetes, epilepsy, gynaecological problems requiring a hysterectomy, an aneurism that could rupture at any time and suspected laryngeal cancer. Two had suffered anorexia for many years and one had developed osteoporosis as a result. One woman described how she had initiated heroin use to overcome physical pain after surgery, 'When I was twenty one or twenty two I had some tattoos removed from my arm. But that wasn't the thing, on my leg where they took the skin from it ripped, the hospital gave me DF118s (*dihydrocodeine*) for the pain, but it wasn't working, I had nobody to help me. To cut the story short, there was this guy who lived across the road who was using heroin, I asked him to get me some, it took the pain away. In three weeks, I had a ten pound a day habit.

Alcohol:

Four of the women abused alcohol as well as illicit substances, one had received a number of prison sentences for violence perpetrated when she was under the influence of alcohol. 'When I'm not drinking and not taking tablets I'm a real nice lass, do you know what I mean? But, when I drink and take drugs I'm really violent. My friends won't come near me because I am violent.' Although she

acknowledged that alcohol played a significant part in her offending behaviour she had not considered accessing any treatment for her alcohol misuse. The other three women also recognised that they were misusing alcohol, but did not regard it as a major problem and did not seek help or advice about alcohol reduction.

Accommodation and income:

Two women in the research were living in hostel accommodation, but a further three said their accommodation was unsuitable and in poor repair. None of the women was in employment and fourteen were in receipt of benefits. Five considered themselves to be living in poverty. Some of the women supplemented their income by working in the 'informal economy' i.e. working whilst claiming benefits. Three women were engaged in prostitution to obtain extra money.

Self- esteem and confidence:

Two women said they had very low self-esteem and confidence, they were unable to socialise or attend groups. One of them had been offered a confidence-building course, but was too afraid to attend. Three of the women said they were not sufficiently assertive to refuse to do anything that was asked of them. One described being a situation where she had started taking care of a friend's children for an hour after school and now they spent virtually all of their time at her house. Another said she would regularly give friends the last of her money, although she did not ever expect to have it returned. Two women said they had no friends or interests at all and spent their time drinking and watching television.

Guilt, shame and stigma:

All of the women experienced and expressed guilt, shame or stigma. Many described the shame of admitting to an addiction and of being seen coming into treatment services, they thought that staff would judge them and were surprised when this did not happen; I expected her (*the DIP Case Manager)* to look on me and say "disgrace", but she didn't.' Others had experienced poor treatment in some services, 'In the hostels, they treat you like animals.'

A second woman commented on the way she had felt about being an addict: 'Even though we are taking drugs, we are still people. You don't get judged here (*at DIP*) but at (*a treatment service*) I felt some staff look down their nose at you, and I left because of that. It's all part of their job though, isn't it?'

A new beginning:

Many of the women spoke about the desire for a fresh start, or a new beginning, but rather than expressing this as an achievable goal, or even a remotely likely outcome, which would indicate positive thinking, the women spoke of this subject as a dream or a fairytale. 'If I could stop using I'd run away, somewhere else that nobody knows me, about my childhood or that. I wouldn't ever bump into my ex or keep hiding from my mother. I could start again and pretend like I was normal. That would be my dream.' Another woman said: 'I think moving to another place, you can be what you want to be – you'd have to be pretty desperate to go out and seek drugs, whereas here, people will offer them to me. As well, I wouldn't tell people about my past and my childhood, I'd keep it to myself, you know? I'd hope they wouldn't ask.'

In speaking about a fresh start the women used language and metaphor that revealed 'magical thinking', non-scientific causal reasoning, which led them to believe that the simple act of moving to another place would resolve all of their difficulties. Magical thinking is common in childhood development, the child who believes it is raining because he is crying is indulging in this process. In adulthood, magical thinking can be linked to mental ill health and psychosis, but there was no indication, in the cases of the women who dreamed of a new beginning, that they were suffering any serious level of mental illness.

Mono- solutions:

The Government has recently published its new national ten-year drug strategy, 'Drugs: protecting families and communities.' On delivering new approaches to treatment and social integration it states 'The previous strategy successfully delivered an expanded and accessible treatment system. This strategy builds on this to focus more on the longer-term outcomes of treatment, including its impact on crime, health and harms caused to families.' (National Drug Strategy 2008:11).

Under the heading, 'Our new approach' (National Drug Strategy 2008:28) it states 'The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs - of dependency. For some, this can be achieved immediately, but many others will need a period of drug-assisted treatment with prescribed medication.' This does not appear to introduce a new approach, but to re-iterate the approach of the previous ten-year strategy, that is

to say, to assume that detoxification or substitute prescribing provide the complete solution to illicit drug use. The section goes on to describe an expected improvement in the health of drug users, as a result of substitute prescribing, that will allow the drug user to '….work, participate in training or support their families.' This contradicts the evidence found in NTORS[1] '…..despite being in regular contact with a medical service, methadone patients' improvements in physical and psychological health were disappointing.'

The strategy document promises that in return for compliance with treatment, 'They (*drug users*) will then be supported in trying to achieve abstinence as soon as they can.' According to NTORS, abstinence is the most commonly desired outcome amongst drug users.

Ashton (2008:5) says focussing on substance misuse alone is too narrow a view, 'What drives most patients to resort to treatment is not substance use as such, but the mess this, combined with the way society responds to it, has made of their lives.'

There is little evidential support for the assumption that substitute prescribing prevents the use of illicit substances, or that it ultimately leads to abstinence. In October 2006 The Sunday Times reported that only 3% of methadone patients in Scotland were abstinent after three years of treatment and compared this to 25%,

[1] The National Treatment Outcomes Research Study 2002

still a comparatively low figure, in England. There are anomalies in the calculation of these figures.

The English figure is calculated including people who are using cannabis and those who are restricting their opioid use to prescribed methadone, whilst the Scottish figure excludes these groups. If the figures were calculated using the same criteria, the percentage of methadone patients who become completely abstinent in England would be much closer to the Scottish outcome.

Returning to the theme of underlying causes, we have seen in this research that for women in Hull these are multiple, complex and varied. The National Drug Strategy 2008-2018 expresses an intention to address the underlying causes of offending, and by inference of substance misuse through Drug Rehabilitation Requirements (DRRs) – a sentencing option wherein the Probation Service provides specific interventions to substance misusers - and DIP. However, within the strategy there is only one fleeting reference to women's needs, a bullet point under the heading of 'Targeting those most at risk'. It claims that The Department of Health will improve access for under represented groups and those with complex needs by 'addressing unmet treatment needs and barriers to treatment, which may include the needs of young people, women, crack or poly-drug users, particularly black and ethnic or other minority communities, sex workers or parents with dependent children.'

There is no indication of how the Department of Health will identify or address areas of unmet need. Neither is there any

indication that the government recognises the complex needs of female drug users, or has any strategic intention to commission services that will work to resolve them. The likelihood is therefore, that national targets and by default local commissioning of services including DIP, will remain focussed on referral to substitute prescribing, with the hope that this will lead to abstinence.

As an added incentive, the strategy aims to achieve re-integration by introducing a new regime that links the payment of both Jobseekers Allowance and Incapacity Benefit to engagement with drug treatment, 'In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment.' The Green Paper 'No-one Written Off' says that benefit claimants will be required to disclose any illicit drug use and will later be required to pay back benefits received, if it is found that, they have failed to declare a drug problem.

Once again, female drug users will be disadvantaged and further stigmatised, 'Many will fail at the interview or even application stage. Drug worker Gina points out that female ex-users face even harsher and more ingrained preconceptions – "employers assume that they have been working girls." Gina says that ex-users have been asked at interview about previous convictions, although legally this shouldn't be brought up until the reference stage of the application' (Craig 2008:13).

Conclusions

The majority of women in this research show that disrupted attachment and the lack of a secure base in childhood has led to unsupported peer selection, causing them to be in contact with substance misusers, at an early age. As a result of emotional need some women made life choices that did not benefit them, for example returning to an abusive partner because of a sense of insecurity. On reflection, many women commented that they had not sought information and support before making decisions, although most knew of reliable sources. This demonstrates poor application of cognitive behavioural skills and possibly high levels of emotional arousal.

Post-traumatic self-medication may be a contributory factor to their substance misuse, given that many of the women suffered childhood abuse, and later, relationship problems. Generally, it is acknowledged that women suffer psychological disorders such as anxiety and depression more than men do and have higher levels of mental ill health, so, self-medication with illicit substances may be an alternative to seeking medical attention, or the corollary of ineffective medical and psychological intervention.

The women are acutely aware of stigma, some delay or resist accessing services because of this. On a cost benefit scale, many of the women regard drug treatment services as high cost/low benefit.

Regardless of their route into drug use, women are differently affected than men by multiple and complex, overlapping problems.

Because of their drug use they are less likely to have family support and more likely to have a partner who is also a drug user, which indicates that they may be suffering financial pressures, be in poor accommodation and where they are mothers, be in fear of official interference in the welfare of their children.

A strong therapeutic alliance between worker and client is generally accepted as being desirable and beneficial in drug treatment and is now being advocated in Probation work as well (Ansbro 2008). This alliance uses the essential characteristics of the secure base to enhance progress in treatment and is highly valued by workers and clients. Ninety percent of the women interviewed, who were engaging with DIP, cited their relationship with their case manager as crucial to their continued engagement.

Practitioners fail to recognise attachment theory as the basis of the therapeutic alliance and the alliance or attachment ends abruptly at the completion of the care-plan, order or licence, potentially leaving the client once more feeling rejected and abandoned.

Female drug users in the research cohort, readily identified a range of practical, emotional and psychological problems, which combine to prolong their addiction to illicit drugs, they frequently refer to 'pain' both emotional and physical as the main barrier to desistance. Regardless, psychology and medical services are not available to the women as an integral part of their drug treatment and the issues go unresolved. Attempts to refer the women into counselling and psychology services frequently result in a refusal,

because substance misuse is cited as their primary or presenting problem. It is common to receive a response from psychology or mental health services stating that they will begin to treat the woman when she has desisted from substance misuse.

'Drugs: protecting families and communities' is the recently published ten-year strategy 2008 – 2018, which claims to focus on the longer-term outcomes of treatment, it informs national targets and local treatment planning and commissioning. The strategy refers to dealing with the underlying causes of offending, and presumably, given its context, of substance misuse. Unfortunately, the strategy at no point expands on this, neither does it indicate any recognition of the underlying causes as they pertain to female drug users.

As a result, drug treatment commissioning is likely to continue to favour discrete services, separate from the generic health and social care services that women need. The emphasis is likely to remain on substitute prescribing, which in Hull is almost exclusively methadone administered via supervised consumption.

Given this 'one-size-fits-all' approach, there is little wonder that women are reluctant to access treatment when all that is on offer, in response to their complex problems and needs, is a legal addiction in place of an illegal one.

There is a better way - Sheehan et al. (2007:302) summarise what works for women as 'an holistic approach.' They explore the innovative work carried out at the 218 Time Out Centre in Glasgow, which provides both residential and non-residential services, exclusively for women. These include drug treatment; health care;

psychological and psychiatric services; alternative therapies such as acupuncture and massage; emotional and practical support on a single and group basis; structured programmes and access to self-help resources such as Narcotics Anonymous and Alcoholics Anonymous all through a single access point. Reports so far indicate that most of the women attending have been able to reduce or stop their use of illicit drugs. There is recognition of the value of attachment and the therapeutic alliance 'A key element of the 218 Time Out Centre is the positive, supportive relationships that are developed between the staff delivering the services and the women who receive them.' (Sheehan 2007: 303). This holistic approach is effective both in prison and in the community, 'The women themselves reported that they gained a lot, both in prison and after prison, from services which addressed all of their problems, rather than focussing on one or two issues.' (Sheehan 2007:303).

A final quote from an anonymous health professional succinctly summarises the 218 approach, the inadequacies of the English drug treatment system and the needs highlighted by the women who participated in this research:

> 'Well, the overall thing is to try and deal with the root causes of women's offending and substance use. Whether it be mental health problems or housing, poverty or any relationship issues or whatever. It's to try and address and tackle the root causes……………' (Sheehan 2007: 100).

Recommendations

Policy recommendations:

1. An addendum should be made to the National Drug Strategy 2008-2018 that adequately recognises the complex and multiple needs of female drugs users and commits to meeting these needs.
2. Central Government and the National Treatment Agency should commit to meeting fully the needs of female drug users, and the practice of directing them into inappropriate, male-oriented, substitute prescribing should cease.
3. Timely and focussed research into what really works for female drug users should be commissioned.
4. There should be clear direction from the National Treatment Agency for Substance Misuse to local commissioners, in respect of the specialist provision that needs to be in place for female drug users and this should be included in annual treatment plans.
5. There should be a single outcome framework, where health targets are set nationally, requiring mental health services and drug treatment services to work collaboratively with patients who present with a dual diagnosis of substance misuse and metal ill health.

Practice recommendations:

1. Practitioners who work with female drug users need to have some understanding the role of attachment in the therapeutic alliance. This could be added to general practitioner training.
2. Care planning should include an agreed disengagement plan, wherein the attachment is appropriately transferred to a worker in a mainstream setting, or a mentor, when drug treatment ends. This will reduce the likelihood of relapse.
3. Specialist services for female drug users need to be developed. These should take an holistic approach, providing a range of interventions, to meet multiple and complex needs, through a single point of contact. This should be offered in both residential and community settings.
4. The practice of directing female drug users into male oriented services, using a 'one-size-fits-all' approach should be phased out.
5. The workforce development plan for drugs workers should be expanded, to recognise and promote a specialist role for those who work with female drug users. A specialist qualification should be developed.

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