

A person wearing a black and white striped hoodie is shown from the side, looking down. The image is overlaid with a semi-transparent purple color. The text is positioned on the left side of the image.

Trauma and recovery amongst people who have injected drugs within the past five years

“It does kind of make
you feel quite numb”

Scottish Drugs Forum with

Richard Hammersley

Department of Psychology, University of Hull

Phil Dalgarno

**School of Health and Life Sciences,
Glasgow Caledonian University**

This Research was funded by **Big Lottery Fund**

Table of Contents

Summary	5
Executive Summary.....	7
Background	7
Childhood	8
Starting & Escalating Drug Use	9
Escape coping' with heroin injecting.....	10
Recovery	10
Types of life story.....	12
Implications for intervention.....	13
Full Report.....	16
Introduction.....	16
Stigmatisation.....	19
Method.....	22
Fieldworkers and capacity development	23
Participant recruitment.....	24
Interview method	25
Data analysis.....	26
Confidentiality.....	26
Ethics.....	27
Results.....	29
Presentation of results.....	29
The achieved cohort.....	29
The social context of participants' lives	31
Childhood	36
Adolescence	42
The nature of 'heroin injecting'.....	45
Pathways into heroin injecting.....	46
Adulthood.....	49
Pathways through dependence	55
Life stories of heroin injectors.....	58
Pathways into recovery	62
Trauma and problem drug use	73
Continuing recovery.....	77
Discussion	79
Implications for services	85
Research objectives	87
Conclusions.....	88

**We would like to thank all the people
who gave their time and effort to participate in this research
and the volunteer fieldworkers
who recruited the participants and interviewed them.**

Copyright © Scottish Drugs Forum, Richard Hammersley, Phil Dalgarno 2013
All rights reserved ISBN 978-1-903483-10-7

“It does kind of make you feel quite numb”:

Trauma and recovery amongst people who have injected drugs within the past five years

Scottish Drugs Forum with Richard Hammersley, Phil Dalgarno

Summary

Volunteer fieldworkers themselves in recovery interviewed 55 people (38 men, 17 women) who had injected drugs within the previous five years, using a structured life story interview. Participants were recruited from cities, towns and villages in Scotland via recovery networks known to Scottish Drugs Forum. Participants described diverse lives which included much as well as drug use. Most had been in work at some point and had raised children, who were very important to them.

For many in the cohort, drug injecting appears to have been a dysfunctional coping response to serious traumas or life difficulties which had often not been recognised before problem drug use developed. Heroin injecting serves to obliterate thoughts and worries, including about trauma. Problem drug use often adds further trauma and life difficulties to pre-existing ones, which can escalate drug use further.

We identified four types of story:

- **Users**, the most common group, whose stories were chaotic and centred on drug use
- **Career criminals** whose stories were about crime from young, a lot of jail, and drugs secondarily
- **Dealers** whose stories were about dealing drugs for long periods of time, when drug use could be taken for granted and was less central to the story
- **Conventional Users** who had worked and had relatively stable lives for long periods of time whilst using drugs, including heroin, until something went wrong.

Participants considered recovery to be being drug-free, or being stable and not using the drugs problematic for them. People recovered with support from drug workers, partners, or other people; either by going to rehab, or while in the community on their own. Almost everyone had used methadone as a support to recovery at some time. Its role varied from temporarily reducing illegal drug use and diminishing chaos, to being a long-term replacement for illegal drugs.

Learning/being equipped to cope with negative thoughts, events and feelings without drugs was an important part of recovery. So was the support of other people, including children and parents. Recovery often commenced only after the person encountered very serious life difficulties, which felt intolerable to them. However, many stories included perhaps equally serious difficulties that had not led to recovery and sometimes had led to increased drug use.

There is a need for services for new drug injectors to focus less on drug use and more on the trauma and life difficulties that they often have, which in these stories had rarely been taken seriously until the person had developed serious drug dependence. There is a particular need for trauma focussed services for new injectors, because injecting drugs tends to be an indicator of underlying life problems and trauma, whether or not the injector sees it that way at the time.

Executive Summary

Background

This research collected the life stories of 55 people who had injected heroin and other drugs within the previous five years but who were currently in recovery. “Participants were recruited through drug agencies and support/recovery networks and personal contacts in different types of geographical areas in Scotland”.

The main aim was to record and understand the life stories of problem drug users, with a view to contextualising their drug problems within their lives and addressing the considerable issues of stigmatisation and stereotyping that problem drug users continue to face.

The interviews used Dan MacAdam’s Life Story method, which involves a semi-structured interview. The fieldworkers who conducted the interviews were Scottish Drugs Forum volunteers and in recovery themselves.

The research occurred in urban and rural Scotland, with areas for recruitment chosen to provide a cross-section of the types of locality in Scotland. Problem drug use in Scotland tends to involve injecting and tends to include the injecting of heroin and other opiates, although typically benzodiazepines are also used, often orally. A wide range of other drugs may be used as well, including alcohol (very often) and cocaine (sometimes).

Most problem drug users in Scotland are from disadvantaged neighbourhoods and are personally disadvantaged. This association between problem drug use and deprivation may worsen stigmatisation, as drug injecting is used as the cause, focus and explanation of all the drug user’s difficulties in life. In contrast, this life story research focussed on people’s lives as they narrated them, which allowed them to describe how drugs fit into their lives as they chose.

People described diverse lives that included much as well as drug use. Common strengths included the importance of family, particularly being a parent. Part of that importance was in moderating drug use and in encouraging recovery. Common problems included childhoods that involved serious abuse or other problems, as well as specific traumatic events before, during and as a consequence of, drug use.

Another strength was the ability to endure somehow extremely difficult and distressing events: for many in the cohort, drug injecting was a dysfunctional coping response to serious traumas or life difficulties which had frequently gone unrecognised before problem drug use developed.

Many people's stories implied that the severity and impact of what had happened to them had not been - at the time - appreciated by themselves, their families, or educational, health and social care services. Indeed, some stories took for granted problems that seemed very severe to the researchers.

Childhood

Only a few people described childhoods that seemed genuinely normal and free of problems around them. Interestingly, most of them mentioned signs suggestive of having serious psychological problems from a young age, including anxiety, attention deficit, hyperactivity and conduct disorders. Their stories suggested personal psychological problems had led to difficulties, trauma and eventually to drug injecting.

Some people described childhoods that seemed to the researchers to be told as "good enough" and happy despite difficulties, because one or more adults had provided a core of stability. Nonetheless, many "good enough" stories included incidents that had the potential to have been traumatic, often related to parental alcohol or drug use.

Some described childhoods with one or more parents who were binge drinkers or alcoholics or who, in a few cases, had drug problems. The stories from these interviewees were of childhoods that were largely unhappy because of persistent, repeated abuse.

Finally, some told of childhoods that had been disrupted and made problematic by a variety of serious problems not to do with parental substance use or their own misbehaviour. This involved issues, such as serious health problems in the family, death of a family member or a difficult parental breakup that, as far as the participant knew, had not involved substance use.

Such problems were remembered as having complex negative effects on the participant, which typically led to them acting out, being defensive or aggressive about these problems, misbehaving at school and getting involved in substance use as a way of having fun and escaping from these problems.

Whether or not alcohol or drug problems were foremost in childhood problems, many people remembering being subject to, or witnessing, violence and abuse when a family member was drunk.

A small number of people recalled that their own misbehaviour from a young age had led to problems in the family and to ensuing traumatic experiences for themselves, such as violence and abuse whilst in care or prison.

Traumas in childhood and early adolescence included:

- ◆ repeated sexual abuse by relatives
- ◆ repeated physical and emotional abuse by parents (including biological parents, step-parents and foster parents)
- ◆ Multiple bereavements, or complex circumstances involving chaos and instability due to:
 - mothers fleeing violent fathers
 - parental mental health problems
 - having criminal or drug-dealing fathers.

Starting and escalating drug use

Using alcohol and drugs relatively heavily from a relatively young age was usually in the context of socialising and having fun, although a few people remembered using drugs to escape from their problems from early on in their lives.

Some gradually escalated their drug use into heroin injecting because their friends were doing it or because they were dealing drugs. Many women started using because they were living with a man who was already using. Some of these relationships had been highly controlling and abusive, with drugs as one element of that; others had been mostly about mutual drug use, which led to various types of misbehaviour towards each other.

Other people described experiencing further trauma on top of what had happened in childhood and adolescence, which led them to inject heroin to cope with it.

Anyone who had begun heroin injecting but quit before developing a serious dependence would not be part of this recovery cohort, due to the recruitment criteria.

A few people had lived relatively conventional lives for years that included working and raising a family, while using drugs including injecting heroin. Things went wrong either because of further trauma or because drug use had a cumulative negative effect on work and income.

The most common additional traumas remembered as triggering problematic drug use were bereavements, particularly the loss of more than one person within a short period of time, and the loss or breakup of the family.

‘Escape coping’ with heroin injecting

For the people interviewed, heroin injecting served to obliterate thoughts that the person felt unable to cope with, including memories of trauma, and worries.

Problem drug use often added further trauma and life difficulties to pre-existing ones which, in turn, typically escalated drug use.

Commonly described traumas related to drug use included:

- ◆ incidents of very severe life-threatening violence over drug debts
- ◆ the murder of close friends and relatives, sometimes apparently in error
- ◆ first hand witnessing of death by drug overdose
- ◆ acquisition of life-threatening injuries and infections related to unhygienic injecting.

Discourse about heroin use often conceptualises these events as effects of drug use that are reasons to quit. For problem drug users, these traumas were also reasons to **continue** heroin injecting, to block out the psychological and physical pain that they would otherwise experience.

Recovery

People described recovery as involving the support of other people and, finally, being able to face up to the horrors they had experienced without feeling the need to block and deaden thoughts and feelings with heroin and other drugs.

Recovery often only occurred after years of problem drug use, which typically had involved many of the following: negative life events; housing problems and poverty; violence; serious health problems; imprisonment; estrangement from family; difficulties with care or custody of, or access to, children.

Therefore recovery was not simply a matter of people eventually being put off problem drug use as a result of appalling problems; many had experienced such problems, tried to stop using drugs, but had failed. Rather, people needed to become aware that, they had little or no option but to face up to their world without heroin.

Previously, their self-awareness had often been hindered by the sedating effects of heroin, which made the users – as they intended - less aware of their very challenging circumstances and less reflective about the causes of them.

This included not reflecting sufficiently on the contribution of their problem drug use to the other problems in their lives. Recovery needed to be with the support of other people rather than for the benefit of other people.

For example, many people had made previous attempts to give up their drug use in order to keep or regain access to their children but, despite these good intentions, found themselves unable to cope with distressing events and recurring thoughts, feelings and memories while un-intoxicated and eventually they relapsed.

Many people felt that their recovery had been hindered by people who either actively facilitated their drug use – such as drug-using partners – or who came to see them as ‘incurable addicts’ (such as family members, neighbours and some health care professionals, including some drug workers).

Recovery was facilitated by different types of relationship with a similar variety of people: new supportive partners, often well-recovered from harmful substance use themselves; drug service staff including auxiliary staff; members of the public who happened to offer support; and, of course, family members who could accept a new relationship that was not defined by the person being a “drug user”.

Many people had attended self-help meetings such as those run by Narcotics Anonymous and had found these helpful. However, the stories told of “support” as being a one-to-one relationship rather than the product of a group. Support seemed to involve being able to accept non-judgmentally the recovering user as someone who had thoughts and feelings with which they needed to cope.

Methadone was regarded as an essential aid on the road to recovery. People were well aware that methadone did not automatically improve their substance use, their behaviour, or their thoughts. However, those who spoke of it felt that it offered the possibility for improvement. For many it had increased stability, reduced the need for street drugs, prevented psychosocial problems getting even worse, and bought time for them to come around to taking recovery further.

Methadone could also serve as an alternative, less potentially destructive, means of deadening distressing thoughts and feelings. Consequently, many stories included the theme of the difficulties of getting and keeping a methadone prescription.

Many people's view of recovery was that it involved being free of all **opiates** including substitute prescriptions. The extent to which recovery involved also being free of alcohol and other drugs varied.

Some people felt that their problem had been specifically with opiates and had found it possible to use other drugs in moderation. Others, usually from past experience, felt that alcohol, cannabis or anything else, were too likely to lead back to drug dependence.

Some people had found that, for them, recovery consisted of being prescribed methadone and using few or no other substances. People were quite clear that being stable, in this sense, was quite different from using a methadone prescription more as a supplement to the other drugs they also felt compelled to take. However, the latter sometimes led to the former, because lighter use of street drugs was a step towards stability.

Types of life story

People's life stories represent how they thought about their lives, which is not an objective history. There were four types of story:

- ◆ Most people's stories were told around drug use, which included periods of chaos when little else had mattered to them
- ◆ However, some people told stories about being a career criminal, who happened to use drugs. This had typically involved spending long periods of time in prison
- ◆ Others told of being a drug dealer, which meant that drug use could often be taken for granted, but which brought its own problems of violence, intimidation and an entrenched and widespread reputation as a problem drug user
- ◆ A small number of people told of living relatively conventional lives for long periods of time, which included heavy drug use. As described above, eventually things went wrong.

People recovered with support from drug workers, partners or other people whilst in the community. Residential rehabilitation and substitute prescribing (as described above) facilitated recovery but did not by themselves produce it.

Implications for intervention

Much previous research has found that drug dependent people have high rates of trauma, both before drug dependence and as a consequence of it. This research has identified the use of drugs, particularly opiates, to deaden the pain of trauma.

This has come to be known as ‘self-medication’ but we prefer to see it in terms of “coping through escape” or “escape coping”. This is because drugs are not being used to medicate against a specific problem but rather as a means to avoid having to remember distressing events, having to feel anxiety, pain or fear and to “insulate” oneself away from the often overwhelming pressures resulting from complex life issues.

Escape coping can become a vicious and counter-productive cycle of behaviour, where increasingly the person is trying to escape from the harmful consequences of drug use by escalating use, and thus worsening the problems that they are trying to escape from.

Consequently, interventions against problem drug use need to take trauma more seriously.

Trauma-focussed services

First, this research supports recent calls for services to be more trauma-focussed and to recognise that many problem drug users have been - and maybe continue to be - traumatised by past and current experiences. Problem drug use is both an escape from trauma and is itself traumatic.

It is essential that services do not see drug users’ problems as ***necessarily*** predominantly caused by drugs, or that drug users’ other problems are undeserving of serious consideration because they are “self-inflicted”, or that their complex problems in themselves should be motives for quitting.

Being more trauma-focussed can involve simply appreciating that many problem drug users have been traumatised, which poses a range of problems for helping them, including:

- ◆ Assessment, particularly repeated assessment by different practitioners, may become highly distressing as clients are asked to go over past traumas repeatedly
- ◆ Addressing the client’s problems prematurely may cause them to flee into further drug use

- ◆ Clients may exhibit a range of dysfunctional behaviours when engaging with practitioners, these are learned means of protecting themselves from further trauma. They can include violence, verbal aggression, insincere charm or compliance, withdrawal or shutting down, and detachment or disassociation from their problems (commonly called ‘denial’)
- ◆ Clients may have highly negative automatic reactions to people and circumstances reminiscent of their trauma. These can include having difficulties with practitioners who happen to remind them of their abusers, having difficulties with ‘authority’ and finding certain environments or cues reminiscent of their trauma to be highly upsetting.

Services need to appreciate that many of the difficulties of working with problem drug users are neither malicious, nor due to the pernicious effects of drugs, but are rather because the person may have been traumatised. Some clients may require specialised interventions to overcome trauma.

However, becoming more trauma-focussed should not always mean reframing problem drug users as totally debilitated. According to the stories told in this research, people had often managed to endure truly dreadful events and circumstances, both before injecting heroin and often while continuing to inject.

Identifying trauma impact in children

Second, 20-30 years ago, according to these stories, troubled children from socio-economically deprived areas of Scotland tended to be seen as problems rather than as deserving of help (although anyone who overcame trauma with professional help would not appear in this cohort).

However, the stories in this research support the idea that children who are acting out or misbehaving at school or elsewhere are often exhibiting signs of serious difficulties such as abuse, parental alcohol problems, bereavement or other serious difficulties in the family.

Alcohol and drug problems present both as a common cause of difficulties and as a symptom of underlying difficulties. As problem drug use becomes entrenched, drugs can be both a cause and a symptom at the same time.

This principle also applies to children who are using drugs and committing crimes, therefore understanding of the underlying issues affecting troubled children and the need for sensitive intervention require to be continually reinforced within relevant agencies.

Empowering clients in recovery process

Third, services should empower clients insofar as this is possible. People described being unable to recover without entering into a mature, deliberate engagement in the process, so it is important that services try to promote the personal capacity of clients to do so.

The sedative effects of heroin and other drugs tend to reduce personal reflection - one reason why people use them. However, many participants in this research had, prior to recovery, also held to one of the dysfunctional beliefs sustaining heroin dependence; that the person is and will be incapable of coping with difficulties and pain without drugs and therefore cannot change.

Services need to be careful to challenge – and provide support to build the capacity of the drug user to challenge – this belief. In particular, they should desist from openly or implicitly assessing or assuming that people are not ‘ready’ to change until their problems have got almost fatally bad.

A care planning approach centred on the person’s ultimate self-responsibility, which takes into account his/her prevailing social circumstances, is recommended. There is also a need for services to make better and increased use of psychological therapies that facilitate personal change.

“It does kind of make you feel quite numb”:

**Trauma and recovery amongst people who have injected drugs
within the past five years**

Scottish Drugs Forum with Richard Hammersley, Phil Dalgarno

Full Report

Introduction

The research aimed to record and understand the life histories of problem drug users, with the objectives of a developing more nuanced comprehension of drug users, their experiences, and the issues that they face. It is hoped that this will inform an enhanced drugs policy response in terms of prevention, treatment and recovery, by offering a more sophisticated and person-centred understanding of “problem drug users” than is currently available.

In Scotland, the foremost form of problem drug use is the use of opiates, especially heroin by injection, often in combination with oral use of benzodiazepines and alcohol. As will be detailed below, the cohort interviewed for the research are best characterised as ‘heroin injectors’, which does not mean that their drug use was limited to heroin or to injecting drugs.

Problem drug users in Scotland tend to be from relatively deprived neighbourhoods and disadvantaged backgrounds. They are further marginalised through being stigmatised socially and legally because of their drug use and related criminality. They can lack conventional social capital, which limits their capacity to move out of, or away from, the personal, social, physical and economic conditions that facilitate and sustain problem drug use.

However, this research discovered two other types of life challenge that may also facilitate problem drug use: stigmatisation and trauma. Stigmatisation requires some initial discussion, which occurs shortly.

This project develops a nuanced understanding of the life histories of problem drug users and how they tell their life stories. There have now been substantial numbers of injecting drug users in Scotland for more than 25 years. During that time, it has become clear that some people recover from drug problems, although the nature of ‘recovery’ is contested.

Consequently, with strict criteria for recovery, such as complete abstinence from most psychoactive substances, relatively few people recover and it may take a long time. However, definitions of recovery in common use more involve personal journeys away from problematic drug use. By such definitions, most people begin to recover eventually, if they survive. For, unfortunately, the mortality rate for drug injectors is very high.

In their lives, problem drug users exhibit resilience and strengths against formidable problems, but research and policy do not acknowledge this well because typically problems other than drug use are thought about as either causes or consequences of drug use.

Yet some people turn to drug injecting as a dysfunctional means of coping with tragic and emotionally scarring personal problems such as serious physical or sexual abuse, multiple bereavement and highly disrupted childhoods and adolescences.

During some periods of some stories, heavy substance use was the least negative aspect of the person’s life.

As will be seen, one function of problem drug use is to block out highly distressing thoughts and feelings and avoid having to deal emotionally or practically with horrific events.

That people can eventually move beyond such events, with or without drugs, is testament to their resilience.

There have been a number of qualitative studies of drug injectors/problem drug users in the UK and elsewhere, including a few in the USA that have followed up user communities for substantial time periods. In the 1970s and 1980s, such research usually framed problem drug use as occurring in a deviant subculture, where activities such as heroin use and dealing were functional. This was when the idea of a “heroin career” was developed.

More recently, many such studies have had a more health-oriented focus and have been designed to understand and deal better with health problems including: service utilisation; ‘chaotic’ lifestyles of crime on the street; gang membership; homelessness etc; blood borne infections; and the difficulties of ‘addiction’ itself.

Such work has often been of considerable practical use. For example, it helped to introduce services that regarded drug injectors as competent agents capable of protecting their health, given appropriate facilities (such as sterile injecting equipment, or naloxone to reverse overdose). Such services in Scotland have improved health outcomes for problem drug users, and their responsible use supplanted a view of problem drug users as, literally, enslaved by their addiction and beyond rational control of their own actions.

Naturally, focusing on people’s drug use and related problems in interviews leads to long discussions centred on drugs, which is what both the interviewer and the interviewee expect. Within a life story, this may not always be a full or rounded depiction of a person, or even of their problems.

SDF stakeholders give accounts of diverse pathways through problem drug use; typically these involved periods of treatment, relapse, stabilised and ‘chaotic’ drug use, voluntary or enforced abstinence. The life story approach however de-emphasises drugs and allows a fuller consideration of how the person’s entire life interacts with their drug use and drug problems.

A drug problem can sometimes be very central and dominant in a person's life, but it is never the entire life.

Stigmatisation

Both the material results of chronic drug use and the stigma of being a drug injector were described as limiting participants' ability to meet the normal challenges of life, to engage with services and supports and to move on. However, it is not realistic to disentangle the material social and health consequences of chronic drug use from how people are thought about and judged, including how they think and feel about themselves.

If drug users had been thought about differently, then they would have been treated differently, which might have changed the material results of their chronic use.

One consequence of the stigmatisation of problem drug users is that it leads to regarding them as passive vessels for their drug problems; people who need help eliminating those problems before they can become normal, active, responsible citizens. Meantime, they are often considered to be unfit and incapable of making their own choices.

This type of thinking, which is often deep-seated, implicit and unintentional, continues to hinder the planning and provision of services for problem drug users as it fails to adequately involve users in the design, planning, commissioning and delivery of those services, and tends to disregard problem drug users' views, particularly when these are inconvenient or unpalatable. This has begun to change within the last decade in Scotland. While the stories told here describe the past, implicit stigmatisation continues.

Scottish Drugs Forum (SDF) represents a variety of stakeholders including drug service agencies, drug user support groups and family support groups and networks. Stakeholders regularly raise concerns about stigmatisation.

Stigmatisation is often implicit and assumed rather than being overtly stated, so it is impossible to describe it definitively. But it commonly includes the following thinking, not all of which is logical or consistent:

- (1)“Drug users have a self-inflicted condition, making them less worthy of services and compassion than people who cannot help their problems.”
- (2)“The main cause of drug users’ problems is drug use, so they urgently need to stop using. Meantime, their other problems are largely what one would expect and are largely self-inflicted.”
- (3)“The effects of drugs, particularly opiates, are such that users are untrustworthy, untruthful and criminal. They stoop to anything to get drugs and the life of drug injecting is inauthentic and valueless because it is entirely about drugs rather than about normal values such as friendship, family and economic stability.”

Stigma results in services working ‘on’ the drug problem, rather than ‘with’ the drug using person. This can lead to inadequate consideration of the person’s rights in treatment, including the general right for people with long term health problems to have a mutually agreed care plan.

Drug users may be judged incompetent parents more readily than other parents based on their drug using status rather than their behaviours. They may be made to endure treatment regimes that would be regarded as unacceptable for other patient groups.

For example, their medication may be suspended for non-compliance with a service’s rules, as judged by a health care professional. In-patient and residential treatment services may have strict rules of behaviour and sanction infractions by discharging clients from care.

Research Objectives

The research had the following specific objectives:

1. To strengthen users' voices through the articulation of their experiences via the systematic research framework provided by the Life Story method, not anecdote.
2. To tell users' stories to:
 - Identify positive pathways away from problem drug use and good practices in relation to this
 - Map the importance of other social, psychological and life history factors beyond 'addiction' in coping with, then recovering from, problem drug use
 - Identify users' and recovering users' unmet service needs
 - Identify strengths within users and within their families and communities that support recovery
 - Challenge stereotypes of addiction by documenting alternative stories of problem drug use.
3. To further develop SDF capacity for user-led research activities.
4. To portray problem drug users lives in their full complexity in order to characterise them as people who use drugs, rather than as passive recipients of drug use; and thereby to reduce stigmatisation by:
 - Offering models of good and bad practice for users themselves, with a view to enhancing their well being and increasing their resilience
 - Challenging stereotypes of problem drug users as uniformly bad and incompetent; to develop interventions to improve their life chances by working to their strengths, and formulating and intervening with their problems in the round, not just their drug problems

- Offering a view of problem drug users that considers their resilience, values and abilities as well as their problems and frailties and emphasises the life experiences that they share with others in their communities, rather than ostracising them as the dangerous ‘other.’

Longer term outcomes (not measurable within the span of the research)

1. Reduce fear about drug users and their social exclusion, by accepting them as imperfect people rather than demonised and alienated addicts.
2. Increase drug users’ involvement in their care planning and in relevant policy debates.

Method

The research used Dan McAdams’ Life Story Method (see <http://www.sesp.northwestern.edu/foley/>, accessed 23/5/2012), adapted for this study by the fieldwork team. It is a semi-structured interview, covering the whole of the person’s life, asking about their childhood, their adolescence and their adulthood. It asks participants to tell the story of each period and to identify the best and the worst experience in each period. It also asks people many of their other feelings and thoughts about their lives, such as the wisest thing that they ever did and the stupidest one.

The Life Story Method is a qualitative research method, which was chosen for this study because its structure encourages systematic recall of key aspects of the person’s life, which in turn allowed participants to place drug use as centrally or peripherally in their stories as they wished.

A common misapprehension about qualitative research is that it cannot address issues of cause and effect. Qualitative research can address cause and effect, but it does so by using a structural logic in the data analysis, not by statistical or other comparisons.

Part of this logic is not to accept people's stories at face value, but to analyse them systematically by coding what is said, to identify interrelated issues and themes that were not necessarily apparent to the participants themselves. For example, some people recognised that their trauma had helped cause their problem drug use. Others seemed to simply take trauma for granted.

Fieldworkers and capacity development

Fieldworkers were recruited from a group of SDF volunteers who were recovering from drug problems. As is standard practice at SDF, fieldworkers were assessed by experienced drug workers. This assessment included an assessment of their stability and ability to cope with this particular piece of work without being unduly upset or being set back in their own recovery. They were also subject to full disclosure of criminal records, as they would work with vulnerable people.

Physical risk to researchers during data collection is a standard ethical consideration in research with various groups of people and this issue was appropriately considered, with fieldworkers assessed for their capability in exercising sense and judgement in avoiding or withdrawing from potentially problematic situations.

The possibility of risk of vicarious trauma from hearing upsetting life stories or discussing drug use was also taken into account. People assessed as too vulnerable were not recruited and after full briefing potential volunteers were able to withdraw of their own accord.

Fieldworkers had support workers. At the end of each day after conducting research interviews they contacted their support worker and discussed how they were feeling and thinking about the day and were debriefed. The fieldworkers could access support at other times if any issues arose.

Fieldworkers received some 50-60 hours of general training from SDF staff and additionally some nine hours of specific training facilitated by the principal

researcher and the fieldwork manager. Sixteen volunteers began the specific training, but eventually six completed it and conducted research interviews. Amongst those who left the programme were people who felt that they would find the interviews distressing, or that they would be unable to conform to the structured approach.

Fieldworkers were very positive about the experience of learning qualitative interview skills, discussing the ethics of interviews and helping to redesign the interview schedule. Moreover, for many of them it was their first exposure to life in a university and they enjoyed the experience.

A number of them inquired about studying at Glasgow Caledonian University and several of them are contemplating taking this forward by various means.

Participant recruitment

Participants were recruited originally through drug agencies and support/recovery networks and personal contacts in different types of geographical area in Scotland during April to July 2011. Deliberately, recruitment occurred in cities, for example Glasgow; in post-industrial towns, for example Kilmarnock; in predominantly rural areas, for example Dumfriesshire. To ensure full participant confidentiality, we are not listing recruitment sites in print.

All participants had received some form of intervention for their drug dependence at some point and from their accounts considered themselves to be currently in recovery. Some specifically mentioned rehab or a self-help programme as important for their recovery. Such programmes tend to include discussion of life in 'recovery' terms. Participants' understanding of recovery is one of the themes discussed below.

It had initially been hoped to recruit participants whose pathways to recovery had not been via these well-known recovery networks, as well as people still using drugs. No active drug injectors were recruited, although some

participants continued to use non-opiate drugs, and many were still receiving methadone prescriptions. Active drug injectors are not likely to participate in a study of this kind with these recruitment methods.

People who recover entirely on their own are difficult to locate by the social referral methods used here. Moreover, as will be discussed further below, the very concept of ‘recovery’ at minimum supposes the development of a problem of sufficient severity that one needs to recover from it. Somebody whose life story includes sometimes using drugs, other times not, may reject recovery discourse entirely, and may not even place drugs centrally in their life story, so may be unlikely to volunteer for a study such as this.

Interview method

Interviews were recorded using digital recorders. Recordings were transcribed by a commercial transcription company specialising in medical and research transcriptions and accustomed to transcribing Scottish accents. The transcripts were then passed to the researchers for analysis, with the recordings available for checking when details were unclear.

Initial reading of the transcripts indicated some differences between peer-to-peer interviews such as these and the more typical interview where a researcher interviews a participant who is from another social world, although the researcher may have made efforts to participant in or observe that world.

Because interviewers and participants shared a common social world, they also shared understandings on many levels. This meant that some issues that might have been explored by professional researchers were taken for granted. For example, there was very little discussion of why people wanted heroin so badly when dependent on it or how this felt.

The common social world also permitted common understandings of slang and allusion, which were occasionally difficult for those undertaking the analysis to understand.

However, the common social world also allowed participants to talk naturally about what concerned them, and to discuss sensitive matters more easily than with a person who had not had similar life experiences.

Data analysis

The Life Story method asks the participant to tell the general story of their life, structured into different episodes, and to answer a series of more structured questions.

Two types of analysis were conducted.

(1) The answers to the structured questions were subject to a simple content analysis classifying the answers, then if appropriate over-arching themes were extracted from the content in a top-down way. In some interviews, the interviewer omitted to ask some of the structured questions, or phrased them differently.

(2) A thematic analysis was conducted to extract common themes from both the life story structured into episodes and the answers to the more structured questions. This analysis was more inductive.

Confidentiality

Participants provided extremely frank information about their lives, which included disclosing much information that they previously might have only discussed during group and individual therapy, if at all.

It is therefore essential to protect the participants' identities by not publishing anything that could identify them to someone else who knew them.

For this reason, as well as anonymising all personal names in the transcripts, all names of places and organisations were also anonymised.

To this purpose, it is sometimes necessary to be vague about details, such as where the person worked, which might identify them. Details of key incidents that had been newsworthy at the time were also deleted to make it difficult to identify them.

Finally, for this report, which potentially has wide distribution, quotes are not attributed to individual participants - contrary to standard practice. This is in order to prevent anyone linking several unusual features or incidents together and identifying a person.

It was felt that it is also important to protect the identities not only of the people, but also of places and organisations that were mentioned in the interviews.

Participants sometimes described the illegal, or simply less than ideal, activities of others. They were also sometimes critical of some of the treatment and other agencies and individual staff within them that they had encountered. Transcripts were read, then all identifying material was removed from them. This included all names: people's names and the names of places and organisations that might make the person identifiable.

Also, any information judged so unusual as to constitute a potential risk of breach of confidentiality was altered. Examples included participation in unusual crimes that had been reported publicly. The anonymised transcripts were then used for the main analyses and the original transcripts and the interview recordings were deleted once this process was complete.

Ethics

This research posed a number of ethical risks for the **participants**, for the **fieldworkers** and for the **researchers**.

Because **fieldworkers** were recovering drug users, and working as a fieldworker involved thinking about and discussing drug use, there was felt to be a potential risk of relapse to substance use.

There was the risk of fieldworkers being upset by the sometimes harrowing life stories they heard, either through vicarious trauma, or because aspects of the stories reminded them of their own lives. Fieldworker assessment and screening (*see above*) was designed to minimise the likelihood that fieldworkers

would be unable to cope with the interviews and SDF also had access to a full range of resources to support and treat anyone who experienced problems.

Given the criteria for participation in the study, there was also a hypothetical possibility of fieldworkers being placed at physical risk during data collection, this was handled primarily by conducting interviews in safe places, such as the premises of local drug services.

The main potential risks to **participants** were: (1) Participants could be 'exposed' as problem drug users by research of this type, which can cause social, legal and personal difficulties. (2) Participants could be distressed by the issues discussed in the interview. The risks of exposure were managed by only contacting potential participants through social networks of known drug users, ensuring that only people who already knew about participants' drug use knew about their participation.

Moreover, all participants were recruited through recovery networks and had been well known as problem drug users in their social networks. Additionally, the transcription and analysis of the data followed strict standards of anonymisation to render it impossible to identify individuals from published details of their life stories.

The risks of distress were handled by fieldworkers being trained to offer basic emotional support, by the support of the fieldworker manager and by use of appropriate referral pathways to address distressing issues raised in the interviews.

Another ethical concern was that participants could disclose information that suggested that they posed a risk to the safety of themselves or others. The consent procedure was explicit about the limits of confidentiality and allowed participants to make the informed choice NOT to disclose such information to researchers. In fact, while participants disclosed many highly dangerous events, these were all from the past. Nobody reported current dangers.

In reading and immersing themselves in the worlds of the participants, the **researchers** were exposed to risk of vicarious trauma because some of the events narrated were harrowing.

Despite being highly experienced in this field, the researchers found it necessary to (a) restrict the number of hours spent reading transcripts and intersperse this work with other less stressful activities, (b) schedule time to mentally shift away from the life stories before engaging in other activities and (c) make occasional use of support and to use cognitive behavioural techniques to avoid ruminating on particularly upsetting details.

Results

Presentation of results

The norm in qualitative research is to substantiate data analysis with the provision of direct quotes from interviews. For brevity, this report only does this to a limited extent; a full analysis of a data set of this size would typically be book length. The academic output that will follow this report will provide further substantiating quotes.

It is generally inappropriate in reporting qualitative data of this kind to focus on how many people did or said what, because the cohort was not a random or representative sample, so proportions are relatively meaningless.

The achieved cohort

In total, 61 interviews were conducted, of which 6 were only recorded in part due to recorder malfunction and could not be used for analysis, leaving 55 to be analysed.

Table 1: Participant Characteristics

Numbers shown are raw numbers rather than percentages. Where these do not add up to 55, there are missing data.

	Male (n=38)	Female (n=17)	Total (n=55)
Mean Age (SD)	38 (6.6)	33 (5.7)	37 (6.7)
Number of siblings in childhood family other than participant			
0	1	0	1
1	6	4	10
2	14	8	22
3	11	2	13
4+	6	3	9
Number of biological children of participant			
0	11	4	15
1	13	4	17
2	5	5	10
3+	9	4	13
Type of place participant had lived most			
City	14	9	23
Small city or larger town	18	7	25
Smaller town or village	4	1	5
Employment			
Has never worked	3	3	6
worked	14	8	22
Worked steadily for years	12	5	17
Much of adult life in jail	9	1	10
Recalled trauma in childhood			
None	5	3	8
Some but no violence or abuse	11	6	17
Violence and/or abuse	16	7	23
Own behaviour caused trauma (e.g. into care)	6	1	7
Closest family member with a drug or alcohol problem			
Nobody mentioned	19	4	23
Parent	14	10	24
Sibling	1	2	3
Other	4	1	5
Mentioned living at some time with partner with drug problem			
No	30	3	33
Yes	8	14	22
Adult trauma unrelated to drug use or dealing (everyone had trauma related to drugs)			
None	19	8	27
Abused by partner	1	5	6
Health problems	2	1	3
Relationship loss or premature bereavement	12	1	13
Other	4	2	6

The majority of participants had worked at some point, although only about a third mentioned working in a stable way for periods of years as part of their stories, and most had children. **Most recalled some degree of trauma, often very severe, in childhood. Over a third of participants mentioned that at least one of their parents had had an alcohol or drug problem when they were growing up.** More women than men had lived with a partner who also used drugs and, **for women, it was often a sexual partner who had introduced them to heroin injecting.**

In adulthood all participants had experienced traumatic events related to drug use and drug dealing. Most people reported multiple serious events, including serious health problems, overdose, the deaths of family or friends by overdose or murder, and experiences of serious violence.

Regarding non-drug related trauma, more men than women reported that the loss of a significant relationship, most commonly a partner or a parent, had been traumatic for them and had significantly worsened their drug use. In contrast, many women reported needing to break up from partners because of their drug use, or less commonly, their physical and mental abuse.

The social context of participants' lives

To understand participants' lives, and how drugs fitted into them, it is important to understand what life is like generally where they live. This section is based upon the interview data, but also upon our background knowledge of Scotland. Most participants were aged between 30 and 50, so they were adolescents between about 1970 and 1990.

Participants came from Scottish cities as well as smaller towns and villages, both nearby the cities and in more remote and rural areas, however some participants had moved around and lived in different types of place and outside Scotland.

There did not appear to be substantial differences in lives in these different sorts of place, except that in smaller places social roles were more fixed and more widely known. So, for example, in a small community the local drug dealing network was unavoidable if one used drugs and, more importantly, if one had drug debts or other problems with them.

Participants from smaller communities reported that it was hard to overcome stigma of being known as a “junkie”, even after they had recovered, assuming that they remained in the same community.

The majority of participants came from, or had ended up in, relatively deprived neighbourhoods characterised by high unemployment. They were stigmatised within the broader community and society because of the association of their neighbourhood with poverty and associated behaviours – whether real or stereotypical - and they were stigmatised within their own neighbourhood community for being drug users.

They were, therefore, perhaps doubly stigmatised and doubly alienated.

There are five relevant aspects of life that need to be described.

- **Marriage and parenthood**

Despite radical changes in social mores and attitudes around sex, parenthood, marriage and illegitimacy, there remains a significant class difference in the social processes of becoming a parent.

Stereotypically, the middle classes reach adulthood, accumulating income/credit-worthiness through education and employment and then going on to have children. This does not apply so much in working class and more deprived communities, where people may ‘settle down’ at an age that is relatively youthful compared to middle class counterparts, or have fewer material/vocational ambitions.

In such communities becoming a parent can be a major driver of ‘becoming an adult’.

Women in this cohort described feelings of being grown up, of the pleasure of finally having someone to care and be responsible for, of the excitement of having adult responsibilities, and often of being in love with the baby's father at the time.

Babies are positive events in many circumstances - even when the relationship between the parents is poor. This applies also to men who can complete their transition from adolescence to adulthood through their parenthood. Grandparents, particularly grandmothers, often play a key role in raising their grandchildren because they are younger than many more affluent grandparents and because parents may need more support as young parents.

That many participants had children young, and then experienced struggles and difficulties in raising them, cannot simply be attributed to their drug dependence or their other problems.

- **Financial survival and crime**

Within deprived communities, many people survive economically by engaging in illegal activities. This contributes to stigmatisation by postcode irrespective of the complex criminological debate about the definition of illegality, which notes that some types of crime, such as fraud and tax evasion, are more common in more prosperous communities.

Some illegal activities have varying degrees of social acceptability within such deprived communities, depending on prevailing cultures/environmental and structural circumstances of the individuals involved. For example, criminologists contrast the intolerance of 'benefit fraud' in some sectors of politics and the media with the tolerance of tax evasion. A less researched area of illegality is the extent to which people, including those opposed to drug use, tolerate or even benefit from the money that drugs markets bring to an area. It is important not to assume that the illegal activities of participants and their families are simply caused by their drug use.

- **Intoxication and violence**

Scottish social norms are quite tolerant of “extreme drinking”, which is our preferred term for “binge drinking”, as long as it does not occur too often or with too many dire consequences.

Extreme drinking at least once a week is not unusual, and with the thriving night-time economy and clubbing scene, the weekend often includes at least one night of heavy substance use, which includes extreme drinking but often a variety of other drugs as well. Consequently, social norms for intoxication, and at least occasional adverse consequences, are relatively high.

Some participants who felt that their childhoods had been happy nonetheless remembered occasional violent fights between their parents, usually while the father was drunk and usually leading to injury to the mother.

The extent to which such events had adverse impact on the participants was highly variable. When they were truly occasional or one-off events participants tended to feel that they had not been harmful to them. When they occurred regularly, then they felt that they were traumatic.

- **Corporal punishment of children**

Many participants felt that it had been appropriate for their parents to administer the occasional ‘slap’ or ‘backhand’ to them, when they deserved it. A few even accepted that they occasionally had deserved a ‘good leathering’. Within the social context, occasional corporal punishment was commonplace when participants were growing up.

However, many participants mentioned patterns of punishment as children that seemed abusive to the researchers in at least some of the following senses:

- Being very frequent
- Being implemented for minor offences
- Seeming arbitrary to the participant

- Involving disproportionate violence up to actual fighting between teenager and parent
- Seeming sadistic to the participant in the sense that they had felt that their parent or step-parent had sought excuses to punish them, rather than genuinely responding to their behaviour.

A commonly used word was ‘strict’. This superficially implies sanctioning minor infractions of home rules, but in reality the parents described as ‘strict’ were always fathers or stepfathers who disciplined children cruelly whilst drunk. This implies that ‘strict’ referred to behaviour which could easily be referred to as abuse.

Occasional corporal punishment was not unusual or viewed as a problem, but fathers being ‘strict’ seemed to be highly problematic. Far fewer women in parenting roles were abusive and alcohol was not remembered to be a factor.

- **Smoking tobacco and cannabis**

Tobacco smoking was not something that came up in most interviews, not because participants did not smoke (indeed many interviews paused so they could), but because it was taken for granted as being too normal to be worthy of comment. Consequently, this study has little to say about connections between tobacco use and other drug use. Moreover, most participants regarded cannabis as endemic to the point that they barely mentioned it, or only mentioned it is passing. Some explicitly said that they did not consider cannabis to be a drug. Some described themselves as being in recovery, which included continued use of cannabis.

Not only was cannabis endemic, it was not generally described as a source of problems - in contrast to some of the other drugs. It could be a source of social difficulties, including the dilemma of letting children see people smoking cannabis and people in the neighbourhood, incorrectly, equating cannabis smoking and problem drug use.

Childhood

Most participants said that they did not have many clear memories before age eight. Difficulties making sense of their childhood stories included that memories were incomplete. Some of the events of childhood, particularly the problematic ones, also had to be inferred by them because parents and the rest of the family had done their best to conceal and not to discuss them with the children at the time.

A recurrent theme for childhood was to normalise behaviour that would have been judged by others to be abnormally violent, abusive and dysfunctional.

Various participants took it as normal that parents were 'strict' and that fathers sometimes beat up their wives. Some also took it for granted that being highly disruptive at school was normal, that being involved young in substance abuse and crime was normal, and that fighting with other young people, including in gang fights, was normal.

When such events were not too common, or too extreme, participants could view their childhoods as happy, despite events that would greatly have concerned health and social care professionals should they have been aware of them at the time. Violent childhoods could lead to participants normalising awful events. One participant whose father and stepfathers had been violent, alcoholic, and criminal said matter-of-factly:

I got hit with a claw hammer and went into a coma for twenty-two days, and I still suffer from migraines today with that. Every time I get clean I suffer with them. I think the drugs have just suppressed it. I had a blood clot it ended up I picked out myself. It was in between your skull and your brain. That was just gang-fighting stuff, and my pal died that day.

At the time, he lied to his parents and the police, claiming that he had been attacked randomly in the street.

Most participants had some good childhood memories, the most common involved family holidays. Achievements as a child and getting new clothes or equipment were also happy memories, which are probably no different from anyone's good childhood memories. However, a few struggled to remember anything happy and one man who had been emotionally and physically abused by his father said:

Nothing really. I never really had much of a thingummy; it was just school or either kept in or out, you know? My mum and dad were dead strict...

Participants reported four types of childhood, which we classified as follows:

- (1) **Normal childhoods** – as perceived by the participants
- (2) **“Good enough at the time” childhoods**, often described by participants as ‘happy’ despite problems
- (3) **Childhoods with parents with serious problems with alcohol, or drugs, or crime, or some combination of these** (the two preceding quotes describe such childhoods), as criminal parents almost always had substance use problems too
- (4) **Childhoods greatly affected by some other serious problem not particularly related to substance use**, although sometimes parents turned to alcohol or drugs as a response to those problems. There were of course life stories with mixtures of these types of childhood.

1) Normal childhoods: Only a few people recalled childhoods where: they had felt happy; they were well looked after; there was no memory of consequential violence or abuse within the family; no other major problems within the family (at least until the participant became the problem); and the family dynamics were stable in that the parents did not separate in ways that were recalled as problematic for the participant.

However, the participants who described childhoods lacking any memorable problems tended to also report signs of major psychological difficulties from an early age (see below). These included signs remembered as commencing aged less than 10 suggestive of anxiety (n=2), ADHD (n=3) and conduct disorder (n=3). All of which are known to be more prevalent amongst people with drug and alcohol problems.

For example one man said that *“I was always quite a hyper kid”* and his story exhibited considerable difficulties with impulse control, including crashing multiple fast and expensive cars. One woman said that her primary school report cards often said *“could be doing better, really chatty, too chatty; far too talkative.”*

She went on to describe a period as an adult when: *“I ended up getting wee cleaning jobs but then the speed (amphetamine) came back into it for me. To help me get about my jobs. Aye I was in this town doing about four jobs, five jobs a day, running home, just giving him (heroin using partner) money.”* Another man remembered always being an anxious kid and using substances to reduce anxiety from the age of seven.

Moreover, the discourse of three participants exhibited some signs of personality disturbance during the interview, such as a lack of understanding of other people’s perspectives, an extreme focus on the self, and difficulties accepting blame or responsibility for bad behaviours.

For example, one woman felt it was extremely unfair that her father, who had bought her a house, had evicted her because she had been dealing drugs from it for several years and was nearly imprisoned as a result. She considered it to be ‘her’ house, although he actually owned it. As she put it:

That’s been from the crap because of my ma and dad and that’s being absolute arseholes with us, and three brothers haven’t been able to deal with what I have being a girl, because all these step idiots, were all idiots. She’s got my fucking house and she’s no relative of my dad and she’s living in my bought house and my dad won’t speak to me.

2. **“Good enough at the time” childhoods:** Quite a few people recalled childhoods that they had experienced as ordinary and happy, and in many cases still talked about as ordinary, but which contained events or issues that had the potential to traumatise the child. Nonetheless, quite often childhood difficulties seemed far less than the challenges that the participants had experienced as adults with drug problems.

The most common ‘unremarkable’ trauma was the alcohol, or occasionally drug, problem of one or more parent. This could have a number of adverse effects. Parents could be ‘strict’ with participants - usually the father, and usually ‘strictness’ occurred after the father had been drinking, although the quantity and frequency of drinking did not seem abnormal for the participant’s social circle. Strictness could involve both verbal and physical abuse. Drinking and/or drug use led to some degree of child neglect, some of the time.

Drinking also led to marital discord. Several participants remembered overhearing frightening arguments, sometimes leading to occasional physical abuse of the mother by the father. Drinking sometimes contributed to the breakdown of the parents’ marriage.

Sometimes, marriages broke down without the participant remembering that alcohol was particularly a factor. During this period, sometimes potentially traumatic events were remembered, such as the children being separated from each other, or being placed in care temporarily, or fleeing an abusive father from place to place. Marital breakdown could also lead to a parent developing an alcohol problem. This could also happen to the surviving parent, after the death of the other parent. Usually, the happy childhood began to get less happy and more problematic while this was going on.

Indeed, from participants’ perspectives parental separation was almost always problematic.

Problems varied from the mother fleeing severe domestic violence and moving repeatedly to escape the pursuing father, to difficulties with cruel or abusive stepparents, to parents turning to drink after separation, to more normal problems including simply resenting the mother for removing the child from the father and consequent acting out by the participant, and manipulating one parent against the other and misbehaving.

“Good enough” childhoods were distinguished from ones with serious problems by the participant remembering a core of stability, provided by some of the adults.

In some families the mother provided that stability and was remembered as being there for the children, despite the father having an alcohol or drug problem, or being abusive, or despite the mother having multiple partners after the participant’s father.

Sometimes, in between drinking bouts the father was a source of stability too, or provided stability when the mother was struggling with a mental health problem, or in one case her own alcohol problem. In some families the source of stability was more complex and varied, with grandparents and other relatives playing memorable roles. Stepparents played various roles in this, from being positive sources of stability, to being both problematic and helpful in different ways, to being highly abusive towards the child and the mother.

3. Childhoods with heavy parental substance use: Another type of family was one where parental substance use was associated with memorable and consequential problems, including the problems of spousal and child abuse and neglect described above, often in more severe forms.

The key difference between this type and ‘good enough’ was that the participant remembered and felt traumatised by parental substance use and/or its consequences. Some struggled to remember any happy events from childhood at all.

As well as there being violence and abuse related to parental drinking, a few participants remembered parents having parties at home that involved heavy drinking by a lot of adults. Some remembered these being fun at the time but various problems were mentioned including children having access to alcohol under age 10 at such parties, children's needs, such as for sleep or food, being neglected while the party was going on, and there being scenes of aggression or violence between adults.

Almost half the cohort remembered sexual or physical abuse, so it is of importance that nobody remembered being abused by non family members at a drinking party, because such events might be considered to place children at risk.

4. Other problems: Some participants recalled childhoods that had been seriously affected by other major problems in the family including having a seriously disabled sibling, having a mother with a disability, moving about a great deal with the mother to escape from the father and the death of the mother, followed by the relapse to alcoholism of the father.

These other problems obviously had direct effects on the family, but they were also remembered as having marked direct effects on the participant including:

- feeling neglected or put second
- being forced to adopt a caring role
- having difficulties in school and with the peer group, where unpleasant and judgemental comments against family members were made, which participants recalled reacting to with violence and aggression.

The problems in the family also led participants to act out and get a reputation for being problems at school, 'nutters' and so on, which they remembered as leading them further into a life of drug use and offending.

In short, none of the participants remembered a problem-free childhood.

However, one must be cautious in interpreting this because people narrate their life stories looking back from their current condition and people who have had drug problems might focus more on childhood problems, seeking explanation for their adult selves.

Nonetheless, many of the problems described were extreme, unusual and readily remembered. Moreover, if anything, the evidence of these interviews suggests that participants tended to take problems in childhood for granted and downplay them.

Adolescence

The norm was for secondary school to be problematic and for participants to leave school at 16, or in reality younger, although a few participants liked school, did reasonably well, or went on to college or relatively stable employment.

Some participants said that they simply hated school. For example, even at primary school: *“I became a serial school-bunking little cunt [Laughter].”*

Some participants exhibited signs of ‘conduct disorder’ from an early age, but in the life stories it was very difficult to disentangle bad behaviours that were responses to childhood trauma from bad behaviours that seemed to arise without reason. Four men remembered being very badly behaved before age 10 without remembering any clear reason for this. Two remembered being involved in setting fire to property (amongst other behaviours) and two had ended up at special schools before age 10 due to their violent and disruptive behaviour in school.

Four participants had ended up in the care system either because their parents were incapable of looking after them, or through a complex mixture of reasons. All four felt that being in care had made things worse for them, but people who had thrived in care would be less likely to be part of this cohort.

Nine participants remembered being seriously physically or sexually abused by a family member, or a step- or foster parent. In only two of these cases had the abuse been disclosed at the time.

Additionally, a few participant interviews described other difficulties that tend to first be observable in adolescence or young adulthood, including symptoms suggestive of depression (n=2) and of eating disorders (n=2), although it is not possible to differentiate effects of drugs from either condition in retrospective interviews.

This may sound as if adolescence was not a happy time for the cohort, but many participants spoke nostalgically of adolescence as a time of fun, thrill-seeking and partying, although it had often included activities that seemed to have involved taking substantial risks.

Some, with hindsight, saw the extent of their partying as a form of escape from problems and warning signs of drug problems to come, others did not. For example, one woman described meeting a partner when she was 13 who was abusive to her and refused to take responsibility for her pregnancy, leading to her having an abortion, as follows:

I met him aye and guess what he done to get my attention? Put his head through a window so I would take him home and pick glass out his head. I should have known then he was a fucking nutter, know what I mean I should have knew. [Laughter].

Many participants had children before age 20, which effectively truncated their period of adolescence. Some expressed regret at not having a longer period for having fun, others with hindsight felt that they had tried to keep up the adolescent lifestyle despite the responsibilities of a family, which had caused problems and contributed to heavy drug use and the failure of relationships. In this sense, and perhaps only in retrospect, they understood the social norms of the community from which they came – see above. **As will be described, all those who were parents felt children were very important.**

Participants had all grown up in an era when drug use was common and by age 16 almost all remembered drinking and other substance use, typically including solvents, cannabis, ecstasy, amphetamines and cocaine (some began using drugs when slightly older). They did not remember this use to be a problem and saw it as quite normal and indeed enjoyable, although some of it sounded quite extensive and some participants recalled ‘loving’ some drugs.

Most people remembered using drugs and drinking in the context of socialising: going dancing; ‘jumping about’ outside with friends in the neighbourhood (including as a gang who got into fights); or consuming them in someone’s home. We called this pattern of use ‘*heavy recreational use*’.

A minority reported use from younger than 11 that already contained signs of dependence to come.

Warning signs in the early teens included using substances alone, using substances to escape from their problems, as well as for fun, using more heavily than their friends, and attending school intoxicated.

For instance, one woman remembered being the girl who drank a bottle of vodka on the bus to the dancing, when her friends mostly waited until they got there to drink. One man remembered inhaling four tins (probably the small ones that used to be sold to make models) of glue a day whilst at school. Two men independently remembered being high on psilocybin mushrooms at school during first year (when they would be about 12).

Several people with highly problematic lives at that time said that as a young teenager their substance use had been the best thing in life. Participants who had used substances like this tended to have had highly traumatic childhoods.

From the outside, their substance use may have been indistinguishable from heavy recreational use, but in their minds it was different. We called this pattern of use “*early onset progressive substance dependence*”, which is not to imply that eventual dependence had been inevitable.

Any young people who had been able to address their issues at this stage, perhaps by receiving the help that they needed to overcome the serious abuse and trauma that they had suffered, might not have become drug dependent, but they would not appear in this cohort.

The nature of ‘heroin injecting’

As described above, everyone in this cohort had used drugs relatively heavily before injecting, and before smoking, snorting or injecting heroin. A few people were offered ‘kit’ and started to use it to cope with pain or grief, usually by smoking, without realising what it was. Many people had injected but had also smoked. Many also injected other drugs sometimes and many took other drugs along with heroin to intensify the effects.

Drugs commonly used alongside heroin injecting are benzodiazepines, particularly valium and temazepam, and buprenorphine, as well as other opiates, should these be available. Several participants described using temazepam, valium or buprenorphine for several years before trying heroin. Once using heroin, people did not necessarily stop taking other drugs too. It would have been impossible for participants to narrate exactly what drugs they had taken how during any period of their lives, or even on any given occasion.

When we write ‘heroin’ we mean use of that drug plus the other drugs listed above. Similarly ‘injecting’ here refers to a lifestyle where heroin injecting is predominant, rather than a literal life of injecting only.

It also must be noted that a small number of participants reported a lifestyle where heavy drinking had been predominant and polydrug use and injecting had played a substantial but secondary role.

Pathways into heroin injecting

Given that participants were using substances at a relatively young age, how and why did people become heroin injectors?

We have already described *early onset progressive substance dependence*. By about 16, the people in this category were trying the drugs associated with injecting, then injecting, which usually began because they were associating with friends who injected (men), or had partners who injected (women).

Many of them remembered loving heroin immediately, despite some people repeatedly vomiting when taking it and the difficulties of injecting it. For someone who uses intoxication to escape their problems, heroin is a powerful way of obliterating thought and concern.

This was not the only pathway. Some women in the cohort described a pattern of heavy recreational drug use, followed by a relationship with a heroin-using partner who eventually introduced them to heroin injecting. Some women knew their new partner was a drug injector, but did not expect to follow; others did not know but eventually found out. All knew that their new partner used drugs.

We shall return to this under the theme of drug supply below, but often being in a relationship with another person who also injected heroin led to intense drug use that endured as long, or longer, than the relationship.

In a slight variation, one woman reported that her partner, with whom she still lived and had two children with, had introduced her to drugs entirely. Previously she had tried cannabis and alcohol and liked neither of them.

According to her she had been so naïve that she did not realise for several years that the 'kit' she had been taking, and helping her partner deal, was heroin or 'smack' - until a customer asked her for heroin.

Some people remembered relatively heavy use of alcohol and drugs that seemed not particularly problematic to them at the time; some characterised it as ‘partying’, followed by a traumatic event, which led them to problem drug use. These traumas were in addition to childhood traumas and included major bereavements and the break-up of significant relationships.

For some participants, trauma occurred before heroin injecting. Others had already injected but described initially having used in a “controlled” manner - in the sense that it was only occasional, at the weekends or limited to what they could easily afford.

Some participants were left with custody and care of the children and struggled to hold life together while taking care of the children and using heroin.

Trauma could be linked to going to or being in prison and the pain of bereavement whilst in prison. Losing access to one’s children could lead to heroin use in prison. Trauma tended to make substance use more extreme, less controlled and more likely to centre around heroin injecting, although four participants described cocaine playing a significant part too. Some people described use escalating very quickly, but others remembered it increasing slowly over a period of months without them fully realising at the time.

A final pattern was that a few participants began using drugs as teenagers, then their use of drugs and alcohol got heavier and heavier as the years went by, until eventually they could not cope with it. Usually, use got heavier in part in response to life difficulties, including traumas. Heroin injecting tended to have played a less central part in the lives of people whose drug use developed in this way.

Rather, heroin injecting was just one of many types of drug using behaviour, which they had tended to indulge in to excess during some periods of their lives.

For example, some reported having an alcohol problem first and foremost, to which they gradually added other drugs.

Several people described that when they were drinking and using other drugs, then drinking had seemed to be the problem, but once they started injecting heroin it eventually became the problem instead.

Others described drinking that seemed probably problematic to the researchers, in terms of quantity and frequency, but had not seemed problematic to the participant.

- **Heroin's unprecedented addictiveness**

All participants were experienced with a variety of drugs, including alcohol, and most were experienced with using drugs and alcohol to excess.

A large number of participants mentioned that the habit of heroin addiction came on faster and more easily than they had realised at the time. Some only realised the extent of their dependence when they were unable to get heroin after a period of weeks or months and were 'rattling' (withdrawing) - symptoms that, initially, some participants believed were due to illness rather than withdrawals.

However, the people whose heroin injecting was just one component of heavy drinking and drug use sometimes injected on and off for years without progressing to complete heroin dependence.

Participants also reported that heroin was intensely pleasurable because it made them feel good, took away pains and, most importantly for most participants, took away worries and cares by making the person feel distant from the events around them.

As one participant observed, this included being detached from the reality of how much heroin one was using, itself contributing to the development of dependence:

You don't realise it at the time but it does kind of make you feel quite numb when you take kit, but you don't think that at the time, that it's doing that, until later on when you're pretty deep in it.

Although people’s pathways through dependence varied (see below), it is important that people found it surprisingly easy to become dependent on heroin. There was an implicit contrast with other drugs that they had taken, including alcohol.

Participants did not describe preferring injecting to smoking because the effects were better. This may be because the fieldworkers had introduced them as peers and that this was taken as a given. They saw injecting as the most cost-effective way of consuming heroin.

Adulthood

Many participants became parents when they were younger than twenty, which is not unusual in the common milieu. Having children was a major means by which participants became adults. However, child rearing and heavy drug and alcohol use are not readily compatible and many participants described struggling to juggle the demands of parenting with the demands of drug dependence.

- **Children**

Parents all spoke positively about having children. For many, the birth of a child had been the most positive event in their life. This applied even for people who had their children when they were very young and it applied also to people – usually men – who had not had much contact with their children or had lost custody or access.

Many participants expressed great love and concern for their children, and regretted if they had sometimes neglected them or exposed them to danger due to their drug use.

In contrast to the routines of violent drunken abuse that some participants remembered in childhood (see above), none of the participants reported physically abusing their own children. If any had done so, they would probably not wish to disclose it, but nonetheless the contrast is noteworthy.

For example, one woman expressed deep regret that at the time she had thought she was looking after her son adequately because she took him to McDonalds to feed him, then shut him in his bedroom with a video so that she could take drugs in peace. While this is far from ideal parenting, it seems preferable to the researchers to the ‘strict’ parenting that some had experienced themselves.

Many participants, including the men, had tried very hard to care for, bring up and look after their children in the most responsible way that they could.

Unfortunately, a common part of the path through drug injecting was that the demands of obtaining and using drugs often got in the way of this. However, as well as describing trying to be responsible parents – even when this meant giving care of the children to someone else – participants also often described that their children had helped to keep them relatively stable in their drug use.

A common pattern was for drug use to get markedly heavier and more chaotic without their children, because there was no longer a need to control drug use sufficiently to care for children and to minimise their exposure to drug use.

For example, one father said his biggest failure was: *“Getting divorced, I think that’s my biggest failure because that was entirely down to me. That was purely my fault, just not being able to see my bairns.”* The divorce was due to his heroin use and he also said that the best thing that had ever happened to him was the birth of his eldest son. Unusually, his father had also been a heroin dealer and user.

Almost all participants had grown up in households where people drank alcohol and, as already described, many grew up with alcohol problems in the family.

Although some alcoholic fathers and stepfathers were reported to have been verbally and physically abusive at times, participants did not seem particularly concerned about protecting their own children from alcohol consumption, or from their drunken relatives.

For example, participants reported letting mothers care for their children, sometimes on a long-term basis, without expressing concern that the children would perhaps be living with an alcoholic and sometimes violent grandfather.

Some additionally grew up with siblings or parents who also smoked cannabis or used other drugs. So as well as the complications of managing one's own drug use whilst parenting, there were also issues about managing other family members' drug and alcohol use in front of the children.

There were concerns about not letting children see drugs being consumed so they might be put in another room in front of the TV while this was going on, or the participant might retreat to the bathroom to inject. There did not seem to be equivalent concerns about alcohol. Cannabis was never mentioned as a concern regarding people's behaviour, or fitness to care for children (as described above, it was not mentioned much at all).

The few participants that expressed concerns were worried about the illegality of cannabis and the dangers of social disapproval or legal sanctions. A couple of participants noted that in their opinion people were mistaken to disapprove of cannabis, or to classify it with other truly dangerous drugs.

However from the hindsight of recovery, many participants realised that they had not cared for their children as well as they now would have wanted, and had exposed them to drug use and its related problems more than they should have. For example, one mother no longer found it appropriate that she had isolated a little boy for long periods in the confines of his bedroom in front of videos, so she could take drugs without him seeing.

Many expressed feelings of shame and remorse about such things, with not being a good parent being a common regret in life, and some discussed the continuing concerns they had regarding being judged as bad parents by family, neighbours and other parents at school because they were 'junkies.'

One woman mentioned continuing to have such concerns, although other parents would have no way of knowing that she had been a heroin user.

From the researchers' perspective, many people have concerns and feelings of shame about being inadequate parents, and many parents sometimes use less-than-ideal childrearing practices such as getting some respite by putting young children in front of the TV. Nonetheless, some of the parenting described was clearly problematic.

Children had some potentially traumatising experiences due to parental drug use. One participant recalled as a young teenager finding his mother so intoxicated on benzodiazepines that he thought that she was dead.

Another recounted a very menacing conflict in her house over drug dealing that, despite there being little physical violence, frightened her young son so much that he wet himself. What concerned her now was that she remembered at the time she had been ready to escalate the conflict to armed violence should that have been necessary, despite the presence of her son.

- **Parents and the extended family**

Most participants felt that their families were very important to them. This applied even for people who had suffered serious abuse by family members. Even in such families, they felt that the family had stuck by and looked out for them and this applied even when there had been major fallings out over the participant's drug use and related bad behaviours.

While a couple of people who had been very badly abused physically and sexually by men in their family expressed pleasure over the fact that the abuser had died, other participants reported that death of the man who had abused them was a significant loss that was difficult for them.

Another feature of family loyalty was that some participants reported keeping good relationships with people married to people who had been abusive to them.

Most participants had experienced significant bereavements, such as the death of a parent, and they reported taking them hard.

- **Bereavement**

One might have expected bereavement to be a common reason for relapse to drugs, but this did not seem to be the case. People who had successfully quit heroin when they experienced bereavement tended to remember coping without relapse. On the other hand, people who were using when a death occurred tended to increase the intensity and chaos of their use. Many remembered being so intoxicated that they barely processed or remembered what happened at the time.

Failing to grieve normally can happen for reasons other than chronic intoxication, and tends to lead to a more severe and delayed bereavement reaction. Indeed, several participants reported that they had continued to use heroin intensively in part because they had felt unable to think about or feel the pain of their loss. Also, several participants reported that one of the major difficulties of ceasing to be chronically intoxicated was that they had to face the painful and unpleasant things that had happened in their lives.

Amongst these things were the premature deaths of family members, partners and close friends due to drugs – that is either by drug overdose, a disease or condition caused by drug use, or by murder related to drug supply. Several participants still found such losses so distressing that they could barely talk about them during the interview.

- **Work and occupation**

Most participants had earned money by working at some point. Jobs included being self-employed at a variety of trades, and work in catering, shops, offices, hairdressing, fishing, forestry, construction, the public sector and many others. A few people had mostly done casual, cash-in-hand, work whilst claiming benefits.

A few people had worked only a little, or not at all, after leaving school until they had children – for the women – and/or they were able to live off drug dealing, or in a few cases other serious crime including burglary, armed robbery and being in an organised crime gang.

Being involved in crime to that extent was relatively unusual, although almost everyone in the cohort had committed crimes to get money for heroin at one time or another. Everyone who had worked reported that heroin injecting and other substance use had negatively affected their work in the end, or sometimes from the beginning.

The main problems were:

- Being sacked for poor timekeeping, because they had not turned up due to intoxication or seeking drugs
- Stealing from or defrauding work to pay for drugs and eventually getting caught
- Taking too much money out of the business to pay for drugs so that it eventually failed
- Ceasing to put enough effort into the business - so it failed.

As well as periods of working, everyone also reported periods when they had not worked. This could be due to ill health unrelated to drugs and to other life circumstances - but it was most commonly due to spending a lot of time and effort pursuing and consuming heroin, making a regular job impossible.

Some had lived this lifestyle in pursuit of heroin for many years. Others had moved towards recovery more quickly and had only one or two years not working. Yet others remembered a more fluctuating pattern of use when for some periods of time they were capable of working, although still using heroin, and other times they were not. Some of the men had spent significant periods of their adult lives in prison, limiting their employability and opportunities to work.

Pathways through dependence

From the onset of heroin injecting, people described a number of different pathways. A few of the younger participants had spent only a couple of years injecting – usually with alcohol and other drugs too – and had then got a methadone prescription and had begun to give up injecting.

This was a common pathway for young women with children who had been introduced to heroin by a partner. Indeed, the women with longer intense times of heroin use tended to have had serious problems other than heroin.

Some participants started between 16 and 22 and then had spent a decade or more injecting, whilst also trying to hold family life together. During their years of use there had often been some periods that they remembered as more stable than others. There had also often been periods in jail and periods of ‘madness’ when life was much more chaotic. The overall trajectory was for their use and the problems associated with it to get worse.

Many remembered being largely oblivious to this at the time, despite what with hindsight (and to other people) were very obvious warning signs, in part because of the mentally numbing effects of heroin.

Some male participants had not started to use heroin heavily until they were older, having previously viewed their drug use as recreational. Their use tended to get very intense and out of control over a relatively brief period of perhaps one to three years, and then it could stay chaotic and out of control for a decade or more. As described above they usually commenced intense use in reaction to trauma. Generally these traumas had involved losses that made them feel that they had nothing important left to live for, so they might as well take heroin without much consideration of the self-destructive consequences.

This was less likely to happen to women, because women tended to have, or want, a bond with their children that kept them going. Men’s bonds with their children could be more tenuous, or the loss of access could be part of the trauma that triggered intense heroin use.

During their ‘heroin injecting’ phase, people used other drugs by different routes of administration - smoking heroin; taking benzodiazepines and other adjunct drugs; drinking prescribed methadone. There were also issues of frequency of use, which we shall return to momentarily.

- **Drug supply**

While many participants had sometimes stolen or committed other crimes to pay for drugs, most participants had also been involved some of the time, to a greater or lesser extent, in the supply of drugs. Although this paid for their drug use, it tended to bring with it more problems than it solved, including becoming involved with gangsters, being in debt to people for drugs and being subject to revenge attacks, sometimes mistakenly.

Aside from domestic abuse, the most horrific violence experienced (and perpetrated by) participants was to do with drugs and being involved in the world of drug supply was a common source of severe trauma. Because the life story method involves an overview of the person’s life, participants did not generally describe routine street level drug deals.

The retail sale of drugs from the home was a more protracted way of being involved in drug supply and for security this ideally involved at least two people, usually a couple, although sometimes a family member and the participant. This could finance the household’s own drug consumption.

However, when children were part of the household, this commonly led the children to being unsupervised and perhaps neglected – for example, being put in a room while drug transactions and use were occurring elsewhere – and exposed to undesirable, even harrowing, scenes of conflict and violence. For some periods, home retailers could be relatively affluent but they mainly spent the proceeds on drugs, for financing their own use was the primary motive for drug selling.

A few participants had been involved in gangs that were involved in the local wholesale of drugs and other illegal activity. These gangs tended to be based at least in part around kinship networks and were described as being dangerous to cross.

One problematic area was the enforcement of prison drug debts outside.

Wives and family members were held responsible for prisoners' drug debts, even when they were estranged from the prisoner. They could be forced to sell drugs when they did not want to, and were trying to recover, or forced to smuggle drugs into prison, on the threat otherwise of their man being seriously injured or even killed. This could happen even if they were estranged from the man in question, because all the gangsters cared about was that they could be coerced into action by this threat.

None of the participants reported getting and staying wealthy by dealing. Presumably anyone who has managed this would not be part of this cohort. Those who had been retailers eventually descended into chaos and crisis, due to the excessive consumption of heroin and drug debts, or got out of dealing before this point was reached.

- **Crime and prison**

Most participants did not perceive themselves to be career criminals (although see below) and described mainly supporting drug use in other ways such as dealing. As already mentioned, many of them had nonetheless stolen money, goods or sold drugs to finance their habits.

The few who described lives more devoted to crime had spent extended periods in prison, sometimes starting to use heroin there. Their adult lives were disrupted by prison and they felt that they had struggled to amend their ways on the outside, because they lacked the life experience to do this.

One man who had served more than five years for attempted murder and started using heroin in prison described life afterwards as follows:

I got out, dealt with – well didn't deal with it – but went through burying my brother, got rid, burying my mum, and then my ex-girlfriend came back to me just after we'd buried my mum, and she fell pregnant. My daughter was born and that's probably what saved my life at that point I think, was being there for my daughter being born; that just lit me up, but it didn't stop me from taking drugs.

Life stories of heroin injectors

Participants tended to depict their lives with drugs in one of four ways. These depictions are stereotypical life stories, not objective accounts of how people had actually spent their lives. For example, someone who saw their self as relatively conventional might well have committed more crimes than someone who saw their self as a career criminal.

'Career criminal': Nine men considered that they had made their living primarily by crime, which they preferred to working. They had either grown up with a criminal father, or had acquired connections to other criminals whilst under 16. Their criminal career sometimes included drug dealing, but in the context of many other crimes. The downside of 'taking the easy way' was that all these men had spent large portions of their adult lives in prison.

These career criminals saw heroin injecting as secondary to the life of crime, and they were amongst the participants who had been introduced to heroin injecting in prison, or in a secure juvenile facility. A common motive for recovery was simply being sick of prison. To recover, they felt that they had had to give up crime, as much as drugs. They tended to speak of their lives of drugs and crime in the past tense. They faced challenges of coping with life uninterrupted by prison, for some of them reported finding prison easier to cope with than the outside, and of finding non-criminal occupation.

Conventional User: Six men and women saw their lives as being relatively conventional, plus drugs. They had worked at normal jobs for long periods of time even after commencing heroin use, until their dependence had become unmanageable. Being conventional did not necessarily involve being in entirely legitimate employment, paying taxes and national insurance. It might instead involve being self-employed but largely off the books, or working cash in hand, which were probably regarded as normative activities in their communities.

Whatever crimes conventional users had committed were seen as secondary to their addiction.

Their motives for recovery were quite complex and varied, including: to maintain or regain custody of their children, life-threatening health problems, and long periods of homelessness and chaos.

Recovery meant giving up drugs and it was imaginable for them to return to or further develop past vocations. However, two men commented that they felt that their materialistic, affluent lifestyles had led to their drug problems, and wished to find occupations that were less just about making money.

Three of the conventional users had been successful enough at some time to be relatively affluent, by the standards of owning a house and a car. This included the people who had begun to inject heroin at an older age. All had spent years working in one job or building up their own business.

Their substance use tended to have been relatively heavy at the same time but they had been able to accommodate this with work because they were self-employed, or because their work was such that substance use was tolerated. For example, one man had worked for an alcoholic, who planned long periods in the pub as part of the normal working day. Only very few people had managed to use heroin and keep work and family life together for periods of years.

Dealer: Six men and women described lives that to them had been about drug dealing as much as about drug use. **The stories that they told depicted drug dealing as a means of funding heavy drug use, which was usually the initial motive, but the disadvantage was being drawn further in to excessive drug use, heroin injecting and crime.**

However, they differed from the career criminals in that they considered other crimes to have been secondary to their drug use. Their stories were more about dealing than about using, which they had been able to take for granted for long periods of time.

Dealers tended to report getting involved in drug dealing and problem drug use at around the same period in their lives. Some initially got into dealing to finance their already growing drug habit, which did not always yet involve heroin or injecting, while others got into dealing because the opportunity was there, often because they lived with or knew someone already dealing.

Dealers described that having a ready supply of drugs escalated their own use. At the time this generally had not seemed like a problem to them, or had even seemed like a good thing, but with hindsight it had made their problems worse.

Dealers tended to have spent less time in jail than career criminals and some of them had managed to spend many years dealing drugs with their partner whilst raising children. **With hindsight, some dealers felt that drug dealing, particularly retailing from a house, had been quite psychologically dysfunctional**, involving feelings of agoraphobia and paranoia, heavily masked by chronic intoxication. One woman dealer had barely left the house for several years.

Drug dealing could involve large sums of money, which sometimes enriched participants temporarily but also facilitated even more excessive drug use, which in turn risked being unable to pay large drug debts. Being in debt to gangsters could be punished with severe, permanently incapacitating, violence.

More insidiously, the gangsters could require increasingly dangerous activities to repay the debt. Several women mentioned being forced to smuggle drugs into prison. Motives for recovery for dealers included wishing to avoid prison – for the scale of dealing that they described risked long custodial sentences – and realising that their lifestyle had got out of hand and was compromising their family’s well-being. Recovery for dealers involved giving up drugs but also giving up the life, which was difficult as they were often well-known figures in their local drug-using networks and because of the tempting amounts of money to be earned dealing. Moreover, gangsters do not wipe debts when debtors desire recovery.

User: Including 34 people, by far the most common of the four life stories. **This story was predominantly about drug use, including heroin injecting, funded by whatever means was achievable at the time.** This could include work, stealing or borrowing off family and friends, crime and drug dealing, but all this was generally portrayed in the story as secondary to consuming drugs. Any planning ended once drugs could be consumed.

Because this lifestyle was comparatively improvisatory and ad hoc, there was a risk of it descending into chaos, when participants lost tenancies, lost custody of their children, had to flee drug debts, were in and out of prison, or became homeless.

We used this as the default category of life story, so any story that did not fit any of the other categories was classified as a User. It is important to appreciate that life being predominantly ‘about’ drugs was how they told their stories, not necessarily how they had lived their lives. However, although the interviews indicate that users had often worked, dealt drugs and committed crimes, these activities were only mentioned in passing in a story that was mostly about the life of using drugs.

Some users’ life stories were patchy and inexact about dates and details. Some explicitly apologised for their poor memories. Many users felt that they

had lost everything to drugs, sometimes more than once. Users used words like ‘chaos’ and ‘madness’ to describe their lives on drugs.

The general motive for recovery was feeling that it was completely impossible to continue injecting heroin. Sometimes this was because it was felt that further use would literally be fatal and sometimes because they had acquired a serious health condition, which was usually drug related.

However, some simply described an epiphany when they recognised that, for them, it was now necessary to stop using. Many users looked back on long periods in their lives when they had felt that they were holding their lives together whilst using drugs, when actually drug use had dominated their chaotic and out of control lives.

Some additionally described periods when their lives had been so dominated by drugs, with as much chronic intoxication as possible, that it was impossible to make any sense of what had been going on. Recovery for users tended to involve giving up drugs and living a quiet life in their own home, usually a tenancy, hopefully rebuilding relationships with their family if this was feasible.

Pathways into recovery

Many participants described the past difficulties of getting any help for their drug problems at all. They did not feel that it had been easy to get a methadone prescription and they felt that it had been extremely difficult to get on to a rehabilitation programme. Probably because of scarce resources for interventions, historically there had been strict criteria for getting methadone, which some people felt it had been difficult to meet particularly while their heroin use was unstable and chaotic.

To get into residential rehabilitation (hereafter ‘rehab’) many people described needing to be in severe crisis. Rehab was described as an important facility for recovery, although options in the community have increased nowadays so the primacy of rehab has probably reduced.

Meantime – and indeed before becoming heroin injectors – most people did not describe receiving any effective help for their psychological problems whatsoever.

With improved services and criteria for service access, we hope that this situation has changed to some extent. Nowadays there are more treatment options than rehab, and methadone is more often prescribed.

Fourteen participants specifically attributed their recovery to a residential rehab programme. Some had needed more than one try at rehab before their current period of recovery. Another 14 cited methadone as the cornerstone of their recovery. Some were satisfied with being maintained on methadone for the moment, with little or no use of the other drugs problematic for them. Some had eventually come off methadone by reducing dose gradually.

Two participants had made use of 12-steps self-help organisations to recover (although many people also used these after rehab). Fifteen participants felt that they eventually stopped heroin by themselves without specific help from services (although they usually had used various services over the years before). The remaining participants did not attribute recovery to any one type of service, often because their recovery had been complicated and drawn out.

Many participants mentioned their key worker or caseworker whilst they were in the community, and two participants explicitly saw their community drugs team/drugs worker as supporting their recovery. However, explicit praise for community support was unusual.

More often this relationship was described as primarily bureaucratic rather than therapeutic; about resources and conforming to rules, and serving as a gatekeeper providing access to scarce treatment resources, rather than about facilitating personal change in the person.

It must however be noted that community support services work with drug injectors throughout their lives with drugs, including when they are at their

least functional, making it more likely that both parties may become frustrated with what can be a difficult relationship that sometimes may not seem to be going anywhere. For example, many community workers have heard clients repeatedly express strong urgent desires to be referred to specialist services, only to not attend should such referral be made.

Some participants described experiencing negative attitudes from NHS and other service staff, who they felt could show their disapproval of people with drug- or alcohol-related problems, which they perceived to be self-inflicted.

Staff may become frustrated or upset with drug injectors, given that many of their life stories depicted long periods of drug injecting despite recurrent serious health and social problems that, from the staff perspective, seem like urgent reasons to change behaviour.

- **Substitute prescribing**

Most participants had been prescribed methadone, often for long periods of time. Only a few had received other forms of substitute prescribing and only a couple had not received any substitute drug. Some described being on and off methadone for various reasons, such as changes in circumstances, moving, and being taken off for violations of the rules.

The cohort generally assumed that addiction necessitated daily consumption of something, so methadone was preferable to street drugs, although methadone often only supplemented and reduced the need for these.

Participants felt that methadone held them sufficiently to make the need for and consumption of other drugs less. Many participants described methadone as an essential component of the recovery process and the concerns that they expressed about it were regarding the historical difficulties of getting, and keeping, a 'script.'

No participant mentioned the philosophical nicety that methadone is a drug so someone on a script cannot have recovered.

A few mentioned the well-known difficulties of the protracted methadone withdrawal syndrome, but nobody thought this made it not worth taking.

At bare minimum, having a script reduced the daily need for heroin and hence reduced the hassles, complications and dangers of funding a heavy heroin habit. The person could go back to using heroin to a more limited extent. A few described trying to quit illegal drugs on methadone, to wind up abusing alcohol instead. Most participants had gradually reduced their methadone dose and some felt that they had recovered, now being stable on a low dose, without other consequential drug use. Others had stopped methadone entirely.

Participants talked of methadone as a good thing, without seeing it as an ultimate solution to their problem drug use. Even people still on methadone maintained expressed hope of being able to stop in the future.

Meantime, having a prescription offered the possibility of using drugs in a more stable and less problematic manner and nobody commented that it had not helped them at all, although participants were occasionally scathing about other aspects of treatment.

All participants who mentioned the issue thought that the ideal was to use only methadone without any street drugs, other than perhaps cannabis, and without extreme drinking. Some who have eventually achieved this type of methadone maintenance were satisfied to be in recovery to this extent for now.

Even at other times, when methadone had merely reduced the extent of street drug use, participants remembered this as being beneficial. However, many spoke of times when they had been on methadone but had nonetheless escalated their street drug use back into chaos. **Nonetheless, they tended to feel that this had not been due to the uselessness of methadone, but to life circumstances or trauma leading to relapse.**

A few were relatively stable on methadone, or had even stopped it entirely, but had not been through rehab. Some had got that way by gradually stabilising themselves without any particular set of events leading to this.

But people who felt that they were in recovery whilst still on methadone tended to report that they had been able to stabilise their behaviour and feelings due to the support of other people, including community service staff and partners.

Partners who were felt to support recovery tended to be new partners who had not used drugs with the participant but who were understanding about problem drug use, often because they had recovered from an alcohol or drug problem themselves.

In contrast, a few participants described having sexual liaisons with other people trying to recover from problem drug use, which typically ended with one or both people escalating their drug use again.

- **Rehabilitation and recovery**

Participants were broadly in two types of recovery. Most described themselves as ‘clean’, having been through some form of treatment programme and were not using opiates, other than methadone, although not all were on that. The extent to which they also avoided other drugs and alcohol varied. Most of the people who had gone to rehab and become ‘clean’, as they understood this, had done so because their life had been in crisis beforehand and had felt unmanageable to them.

Some had stopped without going to rehab. One woman had stopped methadone during both her pregnancies, but had not gone back to drugs after the second one. She was motivated sufficiently by the need to raise her children properly without drug use, and the shame of being a mother who used. She had also encouraged her partner to quit and he too was currently ‘clean’.

I took the wean to school with my mum and the mothers, I can't stand mothers I don't know them anyway but even if I did, I know some of them obviously, cannot stand them I think they are talking about me like [whisper] and I can hear. Partner1 is like "don't be so stupid, you don't look as if you use drugs.

Many people had been to rehab before, but had not managed to stay 'clean' afterwards. Some people mentioned that they had gone to rehab previously because they had felt that they should change for other people, but had not really wanted to. Many participants described how they really loved heroin (and other drugs) to the point that at the time they had not cared about much else – such as their physical appearance, or the state of their home – except their children.

Some believed that they had managed for years to more-or-less hold it together and relatively successfully raise a family while taking heroin. Some had indeed worked, raised children and funded heroin use. However, there was always a risk of this going wrong.

A few people had been able to protect their children from their drug use, for example by only using once they were in bed. It was more common that they did not protect their children from their drug use as successfully as they would have liked.

The crises that led eventually to treatment and change tended to be severe and many people described feeling suicidal and even attempting suicide prior to rehab. However, it must be said that according to participants it was not easy to get a rehab place unless one was in crisis.

If crisis caused a desire for change, this desire seemed to be in the mind of their key worker as much as in the mind of the participant. Or, sometimes not...

I tried to hang myself, the tie snapped. I said to my Care Manager "I need help. I need sectioned." She was like that, "See if you need sectioned, if you're telling me you need sectioned, you're alright today." How the fuck do you work that out. How ironic is that, do you know what I mean?

Some people reported being offered interventions that they did not believe would work:

I was in the process of doing my shit detox in TownX. A three-day detox!

[Laughter]

Fucking nonsense.

Some people had ended up with severe and life-threatening health problems, as well as having chaotic and dysfunctional lifestyles centred around drugs and often involving homelessness.

The recognition that if this continued it would probably lead to death resulted in becoming more determined about recovery, whether this involved rehab or occurred in the community .

On the other hand, some people were able to recover by themselves after sufficiently serious problems.

Often people who had ended up chaotic and dysfunctional had been in rehab more than once.

Others had lost care of their children due to their excessive drug use, which led to depression and worsening drug use, and triggering the realisation that their lifestyle was unsustainable and needed to change.

As well as stopping drug use, this could involve making major changes in lifestyle such as leaving partners who also used, finding stable accommodation, and learning to appreciate the smaller things in life without heroin.

Rehab was therefore definitely associated with recovery, but this was not a simple matter of whether it ‘worked’ or not:

- ◆ **First**, getting a place in rehab was a marker of having serious motives to change, as much as rehab causing change.
- ◆ **Second**, rehab had often not been effective for participants in the past, because they had gone back to drug injecting.

- ◆ **Third**, participants were highly critical of some of their experiences of treatment and of some staff that they had encountered (see previous quotes).
- ◆ **Fourth**, participants tended to comment positively on specific people and services that they had encountered, with which they had developed mutual positive relationships. These relationships could occur anywhere.

Positive relationships seemed to be the main thing that had helped them to change. Often, rehab was the vehicle for these relationships, but it could happen in community services, with a new partner, or even by contact with a member of the public.

So probably it would be two three year ago selling Big Issue on the street, met a wee woman she started being nice to me, being decent to me. She must be about sixty, seventy, so she is older. She is about the age of my mum or something, and we just became friendly.

She would buy me a coffee and talk to me or something like that and I would tell her all my problems and what not and using her to off load on, she would listen to me. I started praying I don't know particularly why, wee shot of religion when I was younger I started praying again.

And she said if I wanted to go to church with her that would be fine, so I went to church with her and just met a whole different crowd of people.

- **Advantages and disadvantages of rehab**

There are a number of residential drug rehabilitation services in Scotland.

Some are Minnesota-model, abstinence-based, 12-steps programmes, which regard addiction as a disease. The remainder are influenced by this form of intervention, but have more flexible and personalised criteria regarding the desirable outcomes of treatment, the nature of addiction, and how progress in recovery should go.

The nuances of treatment philosophy did not interest participants very much, including whether addiction is a disease and what abstinence is. For example, to comfort participants some interviewers explicitly mentioned addiction being a disease, but participants tended to neither agree nor disagree with this idea.

As described by participants, rehab programmes all have common elements including being residential, having rules about behaviour in the residence, and if and when it is acceptable to leave the premises, providing counselling, usually both individually and in group work, and providing a supportive and compassionate environment for change.

Being residential, rehab also provided time out from lives that had often become very chaotic and drug-focussed, which enabled participants to reflect upon their lives and make changes in their thinking, if they wished.

Some participants remembered going to rehab previously with no desire to change their thinking, which meant that it was not effective. One possible issue, which may be historical, was that participants thought rehab places were assigned on the basis of severity of their problems rather than their capability for change at that time.

Rehab was helpful to people because many participants reported that it was the first time that anyone had attempted to get them to discuss their lives and problems; including the challenges and traumas they had experienced before developing drug problems.

The severity of their problems meant that participants did not discuss them easily and the residential and supporting nature of rehab meant that when difficult matters were opened up other people were on hand to provide ad hoc support to them if they became distressed outside of specific therapy sessions. For example, one participant described how the cook had helped her plant flowers in the garden to mourn the death of a family member. In such an environment it was possible to examine one's life, discuss awful things and effect change safely.

However the common idea in rehab (and elsewhere) that addiction is a disease – whether believed fervently or lightly – seemed less helpful for recovery because it risked promoting two related beliefs that seem therapeutically dysfunctional for people who mostly had other serious psychological problems as well.

- ◆ **First**, it led to an emphasis that the root cause of the person's problems was their addiction, which could lead to not taking their other problems sufficiently seriously. The interviews suggest that dramatic life problems such as bereavement, loss, and sexual or physical abuse were taken seriously and often dealt with effectively. However, this necessitated that staff providing interventions were aware of these problems.

Sometimes, rehab was the first place that this happened and sometimes the problems disclosed were overwhelming.

For example, one man who had spent his childhood in care because of his severe behavioural problems and had been abused in care, was advised to leave rehab because staff were concerned that he seemed unable to cope with the things that he remembered during therapy.

Other psychological problems often did not seem to have been addressed or had been treated as secondary to their heroin injecting.

Yet, as described above, some participants reported signs of major depression, anxiety disorders such as agoraphobia, attention deficit hyperactivity disorder, and serious personality disorders, and they reported that the various signs of these disorders had preceded drug injecting.

None of these difficulties are necessarily going to improve because the person is in recovery from drug injecting.

- ◆ **Second**, the idea that addiction is a disease promotes the belief that once using heroin the person cannot do anything about their descent into drug dependence.

This may comfort people who have come out the other side but, again, it makes light of the extensive problems that participants had experienced before becoming dependent.

Injecting heroin, then starting to do so regularly, is a clear sign that all is not well in life and, with hindsight, it would often have been worthwhile someone asking ‘why’ then trying to get the participant help with the problems, ideally before heroin took over and numbed out the rest of life.

- **What is needed for recovery?**

As described above, many participants had recovered by means other than rehab, by stabilising on methadone or in the community with the support of other people such as community workers, self-help organisations or new partners who did not use drugs.

The therapeutic work of residential rehab is relatively explicit, but many participants described two key factors that may be needed to recover successfully.

- ◆ **First, many people described being afraid of having to look at their lives and their feelings properly.** A common belief which had often contributed to heroin dependence was that it would be unbearable to experience sober and raw negative feelings and thoughts about the awful things that had happened in their lives. **The main part of recovery was to actually be able to do this and move on as best they could. Participants described the experience as turning out to be difficult, upsetting, but actually bearable.** In short, people needed to find the strength to tackle something that they were afraid would be unbearable, which was to think about and cope with the difficulties and traumas of the past (see below).
- ◆ **Second, social support was very important.** People made it sound much harder to recover if they had lost their family and children and had no realistic hope of reconnecting with them. People who had been in this situation had often been chaotic and homeless for years and had literally focussed entirely on heroin.

What drove them to recovery eventually was a basic realisation that they did not want to die and that they would die if they continued to use. Although they had felt that they had nothing to live for and had exposed themselves to situations where there was a substantial risk of dying, in the end they wanted to live.

People who had remained more connected with their children and families described the desire to develop better relationships as a major motive for recovery. As described above, the support of even one person for recovery seemed to be extremely important.

Trauma and problem drug use

We have already discussed the difficulties that emerge from conceptualising drug addiction as being the main explanation for people's life difficulties.

Additionally, seeing drug addiction as caused primarily by the drug begs the critical question of how and why most drug users do not become addicted. Even in this cohort where everyone had eventually become heroin injectors, a few people described first using heroin for long periods of time while holding a relatively normal life together.

Another explanation of the development of drug dependence is that it is a dysfunctional form of escape coping from life's problems. Boris Cyrulnik's theory of trauma and resilience offers a clear model of how this could occur.

According to trauma theory, although many traumatic events are dramatic and horrible, more mundane unpleasant events can also be traumatic for the person. One relevant example is being bullied at school.

It is the person's reaction to the event, not the objective severity or unusualness of the event, that determines the scale of the person's trauma; what seems like horsing about for one child can be traumatic for another.

Additionally, people often cope reasonably well with one trauma even if it is very serious, but struggle to cope when two come along relatively close together, or when the traumatic events are repeated, as in child or domestic abuse.

Traumatised people also may appear to carry on and superficially be coping quite well, but they are much less likely to be able to cope with further adversities or traumas later on in life.

Finally, traumatic experiences are a source of resilience as well as a source of psychological problems. For example, traumatised people can be more compassionate afterwards and take a calmer view of everyday hassles.

- **Trauma related to drug use**

Many people described traumatic events related to drugs that, had they been unrelated to drugs, would have warranted counselling. There were incidents of extreme violence, and incidents of very serious health problems.

Extremely violent incidents related to drug dealing included: being shot in the face; being stabbed; being nearly thrown out of a flat window; and having a gun held to the head.

This had happened several times to one man, whom we quote at length to illustrate the extremes of violence that can be involved:

I mean when that happened to me last time it happened it wasn't long before I came into treatment, and I told them to pull the trigger.

I: Did you?

Which is not a clever thing to do.

I: No [laughter].

But it was kind of my mate got smashed by a sledgehammer right in front of us, right beside us at the back of the motor, and I thought the two of us were getting it. And they took the two of us away and they drove off the bypass and down a back road, and they had a knife and the rope. And I thought we are getting tied up or just shot, I didn't know I was stabbed I didn't know what was happening. And I was full of fear and I was shaking myself and I didn't want to be in that situation that you can't do anything about.

But one of them started bashing about with this mini sledgehammer on him, done his knee in and his arm and copped it in the face as well, the back of the head and all that and he got a dog onto him. And I thought I was next but it was his debt and that is why these guys grabbed him originally, and I was just unlucky to be in the wrong place at the wrong time and it was nothing to do with me and that is why I didn't get. But I thought I was getting it because I had witnessed it and all that stuff was going through my head.

A number of people had committed terrible crimes whilst drunk and drugged, including stabbing a brother multiple times over drugs, shooting their sister's boyfriend with a shotgun because he made a sarcastic comment, and murdering a man in a drunken jealous rage.

People who had done such things regretted them, in part because they had led to long prison sentences, and blamed alcohol for their over-reactions. Many of these violent incidents were secret, but even when they were public, neither victims nor offenders were offered any counselling for them.

Some participants had also been involved in serious violence more to do with gangsters in general than drugs in particular. For example one man had been an enforcer in jail for a gang:

And I would be on the phone he'd say scald him, I have to put some sugar and water in big continental cups and throw them at this guys face. I have got to do this because if I don't then I am discredited, my credibility is out the window. The guy had his own protection and that...

I: Man that's terrible.

Serious health problems included being HIV positive, having partially lost use or mobility of a limb due to infections at injecting sites. Additionally, several participants reported experiencing the drug-related deaths of many friends, in some cases people had literally died in their presence. At the time and being sedated with heroin and other drugs, they had not really processed these events, but they had often had to cope with them during recovery.

- **Trauma unrelated to drug use**

However, participants also reported equally traumatic events, both as children and adults, which were not particularly related to their drug use or obtaining of drugs. Common traumas as children have already been outlined.

Adult examples include:

- Both one man's parents died and he lost access to his children whilst he was in prison
- Another was drugged with flunitrazepam (Rohypnol) whilst drinking and raped
- Several had family members who were murdered
- Another was seriously assaulted as revenge for something that he had not done.

Participants also reported many bereavements that were not related to drugs but were often related to smoking (lung cancer and emphysema) and drinking (heart attacks). A remarkable number of participants had experienced the murder of family members.

Consequently, most of the cohort had experienced trauma as children – although some of them thought that what had happened, for instance 'strictness', was quite normal – and all of the cohort had experienced trauma as adults, much, but far from all of it, being drug related.

- **Impact of trauma**

According to trauma theory having childhood trauma makes it more likely that the child will develop 'problem behaviours' as a teenager, which include heavy substance use.

Moreover, having one or a succession of traumas makes it likely that further trauma plus heavy substance use will lead to the dysfunctional coping response of becoming dependent on heroin. If heroin and adjunct drugs had not been available, then most likely the traumatised person would have abused alcohol instead.

Whilst dependent on heroin there is often further trauma, which makes it even more difficult to cope with the upsetting and horrific memories and thoughts that emerge when the person tries to cease being chronically intoxicated.

However, trauma could also be a factor in recovery. As already discussed, it was difficult to get a place on rehab without being in crisis. Additionally, trauma on top of previous trauma sometimes made people realise that they simply could not continue their current lifestyle.

Continuing recovery

Most participants felt that recovering from their heroin injecting had been the biggest challenge, or amongst the biggest, of their lives.

Other big challenges tended to be to do with keeping custody of their children. Most felt that the wisest thing that they had ever done was going to rehab or something else to do with getting off heroin, such as splitting up with a partner who would not quit, or “Starting to listen to what doctors and counsellors advise.”

Most participants also felt that using drugs was their biggest regret about their lives.

Consequently, most participants had spent considerable time focussed on trying to no longer be drug dependent. They varied on how long it was since they had not taken heroin and its allied street drugs, so what they hoped was next for them was quite varied.

However, plans and ambitions for the future included:

(1) continuing recovery, by coming off methadone completely, continuing treatment, or attending NA meetings

(2) establishing a normal, stable domestic life that included their own house, relationships with whatever children they had, better relationships with other family members and some form of job to provide economic stability

(3) seeking pleasure and contentment from personal relationships and the small things in life

(4) finding a meaningful occupation that would allow them to “put something back”; this might be paid or voluntary. The most common plan was to get more education and go into counselling or drugs work of some kind.

Interestingly, people’s visions of recovery did not include plans or hopes to become wealthy or successful.

The minority of the cohort who had experienced conventional success in life had also experienced this collapsing around them and had discovered that material success had not sufficed for happiness and was not important to them.

The majority of the cohort who had less conventional success had often had experience of transient wealth, due to drug dealing, and also had experience of the conspicuous consumption of drugs. They had learned that aspiring to feel good all the time by being intoxicated had not made them happy either.

Moreover, several people expressed concerns that if they became affluent in the future – by legal or illegal means – there would be a risk of them relapsing to heavy drug use.

Some people could currently look no further than (1) - continuing recovery - and some wanted no more than (2) - a normal domestic life at this point, if it was possible for them. However, many also sought (3) - modest pleasures and (4) - to ‘put something back’.

In short, participants wanted to have ‘normal’ lives and to be happy.

Discussion

Types of story

Drug injectors' life stories could be classified into four broad types that we called **Users, Conventional Users, Career Criminals** and **Dealers**.

Users

The most common story was the **User** story, which most closely fits some of the stereotypes of drug injectors. There were indeed stories that had included periods of chaos, violence and excessive drug use with little regard for the person's own health or the impact that they were having on others - except that, throughout, people valued their children.

Most of the life stories told here were only chaotic for part of the life. There were often also periods of much greater normality. These could include periods where people were using drugs heavily, but also working and raising a family.

However, some people never had this opportunity for any length of time, because they got into heroin young, and/or went to prison young. Their lives could have no period that seemed 'normal' before they began recovery.

Many users would have benefitted from interventions that started earlier on in their drug use, and that addressed the life difficulties and traumas that they were trying to escape from.

Some users recalled that at the time they had thought they were having fun, but with hindsight and awareness of how their drug use had escalated they were already showing signs of problems.

Many were using drugs and a dysfunctional means of escape coping before they had injected heroin.

Conventional Users

A minority of participants were **Conventional Users** and described lives when for long periods they were fully participating and productive members of society in the sense that they were employed, raising a family, in stable housing and not short of money.

Interestingly, these people thought recovery should involve less consumerist and materialistic values, for their normal, productive lives had not protected them from drug dependence and had not sufficed to make them happy. They had used drugs as part of leisure activities and because they could afford to do so.

As they became more affluent, so they had tended to use drugs more, eventually developing a problem.

Conventional Users tended to not remember using drugs for escape coping. Rather, they used them for leisure and recreation. However, with access to and funds for drugs, and accustomed to their use, it was possible for them to turn to escape coping when they encountered severe life problems, such as the breakup of a relationship and loss of access to children.

‘Career Criminals’

Another minority of participants saw themselves as **Career Criminals**, having got heavily involved in crime before they had injected heroin and having spent lots of time in prison.

Some career criminals recalled a very rapid trajectory into crime from childhood, sometimes because they were raised with a criminal father or in a criminal social circle, and sometimes because they had been in care or been neglected and a life of crime was all that they knew from young.

However, some career criminals saw their childhood offending as inexplicable and attributed it to their nature. Drug use, including heroin use, was a part of the criminal lifestyle for career criminals. So was prison, where some had first used heroin. **We believe that for career criminals often it was impossible to change their drug use without changing their offending and that the core of their problems was offending and repeated imprisonment, rather than drug use itself.**

Drug dealers

Another small group of people told stories about being **Drug Dealers**. They had tended to get heavily involved in drugs and involved in drug dealing around the same time, often because they knew someone who was already dealing.

Becoming a Dealer had - with hindsight - made their drug use worse because they came to use drugs more heavily and frequently, all injected heroin and some injected cocaine too.

With a generally ample supply of drugs, Dealers told of being chronically intoxicated sometimes for years on end. This had allowed them to ignore or be indifferent to other serious problems related to dealing including violent enforcement of the black market, police activity against them and coming to live a lifestyle of mistrust and social withdrawal.

To recover, Dealers needed to stop dealing as well as stopping drug use. A challenge was to get the community to accept that they had stopped dealing as the police, gangsters seeking people to sell drugs, users seeking drugs and the general community all tended to assume that they might not really have stopped.

Looking at the participants as a whole, they often described a social world that often included heavy drinking and where alcohol problems and domestic violence were not unusual.

Cigarette smoking was so normal as to barely pass comment, but many participants had experienced the death of family members from smoking related causes. Cannabis use was also common, although it was contested because some people in a neighbourhood considered it to be ‘drugs’ whereas others considered it to be so harmless as not to even be a drug. The context of heroin injecting is often a social world where intoxication is not unusual.

Factors contributing to heroin dependence

For the development of heroin dependence, the stories told suggest that two contributing factors are very common: alcohol and trauma.

Alcohol problems in the birth family often led to abuse and trauma but there could also be trauma for other reasons. People who remembered childhoods free of potentially traumatic events and circumstances were in the minority and remembered signs from young of having other serious problems, such as ADHD. However, many of the life stories of this cohort were soaked in alcohol.

Heroin use sometimes became heroin dependence very quickly but a few people, mostly Conventional Users, managed a more controlled pattern for some years before succumbing to dependence. The development of dependence from heavy drug use was often also associated with trauma.

A partial exception was that some women formed relationships with men who injected heroin, and introduced them to it. Intoxication on heroin blocked the pain of past trauma and made it very difficult to cope in a healthy manner with future trauma.

At the same time, life acquiring and injecting heroin was commonly associated with further trauma, which made the possibility of coping unintoxicated seem even less likely.

The stigma of being a heroin user

From these life stories, we believe that the stereotype of the chaotic ‘junkie’ has some very adverse consequences for people who inject heroin. It focuses solely on the worst period of their lives and their most dysfunctional aspects.

The stereotype lowers expectations of injectors to close to zero and trivialises the often terrible things that have happened in their lives by attributing them to ‘drugs’. Users themselves, families and services come to feel ‘What can you expect?’

Some participants described only finally getting adequate help when the severity of their problems had become even worse than this supposed norm. Before that, sometimes they sought help but did not get it, and sometimes they did not seek help when they should have.

The stories suggest that heroin injectors, their families and the services that work with them can become inured to very serious problems - a process facilitated for heroin injectors by the drug’s numbing effects.

Heroin can become an all-encompassing excuse: relative murdered, loss of a limb, kneecapped, lose access to one’s children; “*What can you expect?*”

Abstinence becomes the all-encompassing solution but, meanwhile, support can be lacking. A major challenge is that chronically intoxicated people are not particularly receptive to support, at least as usually offered by services. For instance, most effective psychological therapies do not work well when the client is intoxicated. There is a need to devise more appropriate interventions, rather than waiting, or blaming the client for continued intoxication.

Factors promoting recovery

We identified two factors that promoted recovery which were:

- **learning to deal with thoughts and feelings, particularly negative ones, without intoxication**
- **having social support, particularly while experiencing negative thoughts and feelings without being intoxicated.**

For some, rehab provided the opportunity to address thoughts and feelings, and gave social support but these could also be obtained in the community from drug workers, family, new partners and, indeed, members of the public.

Implications for services

Traumatised children may not fare well as adults and one of the ways that this happens when heroin is available is that they become heroin injectors, usually after further trauma.

In theory, children should get help if they act out at school or if they are known to have experienced serious traumas or difficulties such as being bullied, being a carer, being abused, suffering bereavement, or having a major problem in the family.

Most service and policy documents mention such issues as priorities. Unfortunately, most participants had no recollection of getting any help as children. They usually described that misbehaviour at school led to being treated as a trouble maker, rather than being treated as troubled.

Although there are major resource implications of taking difficult children seriously, the consequences of failing to do so were terrible in this cohort.

These life stories identify a clear gap in service provision, which is to provide services for people who recently have begun to inject drugs before their lives descend into chaos.

Nowadays, people are more readily prescribed methadone **but the key objective of services for recently initiated injectors should be not to stabilise drug use but to treat the difficulties and trauma that have led to drug injection.**

The life stories also identify some barriers to this including that new injectors tend to see heroin injection as another recreational drug with particularly powerful and enjoyable effects. They also tend to use heroin to obliterate self-reflection and therefore may be unreceptive to psychological interventions.

However, they might be more receptive to therapy for trauma, then to therapy aimed at dissuading them from heroin use. This would also have the advantage that anyone truly using heroin recreationally or in a controlled manner without prior trauma could simply decline to be treated for trauma that they had not experienced.

At that point, crisis interventions aimed at addressing whatever is troubling the person might be more readily effective than later interventions to treat their now fully developed drug dependence. At that point too, people also might be able to stop more easily.

With the wisdom of hindsight, it is quite obvious that someone who has lost several family members in a short space of time and has started injecting needs some help. Currently, people all too often only get psychological help when they have developed serious drug problems, if even then.

Earlier interventions would require both more trauma mindedness in generic services and having an appropriate specialised service that could help people cope with trauma. Such a service would need to consider how to work psychologically with people in crisis who are escaping coping with chronic intoxication. Some form of behavioural contract between therapist and client would clearly be required, such as agreeing to not come intoxicated to treatment.

It is also important that people who were recovering described the process as one that required their mature, deliberate engagement, even if they had not realised that this was required when they began the process or had feared that they were incapable of it.

Therefore, it is important that services encourage and equip the user to take responsibility for their lives – as in the care planning approach – even when they do not always behave in a responsible or controlled fashion.

Also, people will often be considerably reluctant to ask for help, due to shame and stigma, so when they ask for it, they should get it.

A core set of dysfunctional beliefs that sustains heroin dependence includes that the person is and will be incapable of coping with difficulties and pain without drugs. Many participants in this cohort had these beliefs. Services need to be careful not to sustain them, particularly by openly or implicitly judging people not 'ready' to change until the problems have got almost fatally bad.

The cohort was broadly positive about methadone although it was rarely a cause of personal change and growth by itself.

At least there are currently the resources to give methadone widely, for receiving it eases some of the problems that participants described regarding obtaining illegal drugs.

However, inappropriate over-reliance on methadone and other substitutes also makes drug problems even more 'about' drugs, both for users and services, when we believe that these people's life stories suggest that acquiring and recovering from a drug problem is about life, not only about drugs.

Substitute prescribing also risks retarding community drug services to focus mainly on the provision of methadone. The bureaucratisation of substitute prescribing can be involve time consuming regulations and paperwork, which can prevent there being sufficient time to build a therapeutic relationship between client and counsellor that could facilitate recovery.

Research objectives

To what extent has this research project met its objectives of (1) Strengthening users' voices, (2) telling their stories, (3) developing SDF research capacity and (4) portraying problem drug users' lives in their full complexity?

Of the four objectives, all but (3) can be judged by the reader and our asserting that they have been met adds little. The project has also developed SDF's research capacity, both in demonstrating that volunteers in recovery can engage in all aspects of research and in increasing the sophistication of the types of research of which SDF is capable.

Conclusions

Trauma is clearly a significant factor in helping fuel the size of Scotland's drug problem. Failure to respond to trauma effectively stores up significant future problems for which the individuals, their families and wider society pay a huge price. Given the scale of trauma highlighted here, there is a need to review trauma and related services to ensure they have sufficient reach to intervene as early as possible in troubled lives.

Similarly it is clear evident that progression to heroin use and injecting is a sign that an individual is 'troubled' and unable to cope with their life experiences appropriately.

For specialist treatment services there is a real challenge to look at the accessibility of their services and whether it is possible to intervene earlier to enable the addressing of underlying causes prior to a drug problem becoming entrenched. This requires services to have the capacity to enable individuals to reflect on and address the range of problems they present with, rather than a narrow focus on drug use.

For those with more entrenched problems, the study identified for many the benefits of substitute medication and its ability in stabilising chaotic lives.

Alongside this was the need to look beyond the presenting problem of heroin use and allow a safe space to encourage the underlying problems to be acknowledged and faced.

This time and space for reflection was more readily available for this cohort through residential rehabilitation although it could also be achieved in the community, which has probably become more likely as there are more resources and training for community services now than there were in 1987.

What is evident is that high quality and effective psychological therapies need to be more widely and easily available **across all services** to help people with substance use problems overcome the impact of pain and trauma in their lives.

Selected Further Reading

- Agar, M. (1973). *Ripping and running: A formal ethnography of urban heroin addicts*. New York: Seminar Press.
- Aldridge, J., Measham, F., & Williams, L. (2011). *Illegal leisure revisited: Changing patterns of alcohol and drug use in adolescents and young adults*. London: Routledge.
- Bourgois, P. (1995). *In search of respect: Selling crack in el barrio*. Cambridge: Cambridge University Press.
- Cyrlunik, B. (2009). *Resilience*. London: Penguin.
- Elliott, D. S., Huizinga, D., & Ageton, S. S. (1985). *Explaining delinquency and drug use*. London: Sage.
- Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S., Heckman, J. (2004). *Enhancing substance abuse recovery through integrated trauma treatment*. Rockville MD, Center for Substance Abuse Treatment.
- Golub, A., Johnson, B. D., & Dunlap, E. (2005). Subcultural evolution and illicit drug use. *Addiction Research & Theory*, 13(3), 217-229.
- Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.
- Hammersley, R., & Dalgarno, P. (2012). *Drugs: Policy and practice in health and social care*. Edinburgh: Dunedin Academic Press.
- Hammersley, R. (2008). *Drugs and crime: Theories and practices*. Cambridge: Polity.
- Hammersley, R. (2011). Pathways through drugs and crime: Risk, resilience and diversity. *Journal of Criminal Justice*, doi: 10.1016/j.jcrimjus.2011.02.00
- Johnson, B. D., Goldstein, P. J., Preble, E., Schmeidler, J., Lipton, D. S., Spunt, B., Miller, T. (1985). *Taking care of business: The economics of crime by heroin abusers*. Lexington MA: Lexington Books.
- Levy, J. A., & Anderson, T. (2005). The drug career of the older injector. *Addiction Research & Theory*, 13(3), 245-258.
- Maruna, S. (2008). *Making good: How ex-convicts reform*. Washington DC: American Psychological Association.
- Mills, K., Teesson, M., Darke, S., & Ross, J. (2007). Reliability of self-reported trauma exposure among people with heroin dependence: A longitudinal investigation. *Journal of Traumatic Stress*, 20(3), 313-323. doi: 10.1002/jts.20219 ER
- Mullen, K., & Hammersley, R. (2006). "After you've ran with the rats the mice are a bore." cessation of heroin use amongst men entering mid-life. In W. Palacious (Ed.), *Cocktails and dreams: Perspectives on drug and alcohol use*. New Jersey: Prentice-Hall.

Neale, J. (2000). *Drug users in society*. Basingstoke: Palgrave.

Plumridge, E., & Chetwynd, J. (1999). Identity and the social construction of risk: Injecting drug use. *Sociology of Health & Illness*, 21(3), 329-343.

Reinarman, C. (2005). Addiction as accomplishment: The discursive construction of disease. *Addiction Research & Theory*, 13(4), 307-320.

Schilling, E. A., Aseltine, R. H., Jr., & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: A longitudinal survey. *Bmc Public Health*, 7, 30-30. doi: 10.1186/1471-2458-7-30

Taylor, A. (2003). *Women drug users: An ethnography of a female injecting community*. Oxford: Oxford University Press.

Torchalla, I., Nosen, L., Rostam, H., Allen, P. (2012). Integrated treatment programs for individuals with concurrent substance use disorders and trauma experiences: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment*, 42(3) doi: 10.1016/j.jsat.2012.01.006

Zinberg, N. (1984). *Drug, set and setting: The basis for controlled intoxicant use*. New Haven: Yale University Press.

Main Office

Scottish Drugs Forum

91 Mitchell Street, Glasgow G1 3LN

t: 0141 221 1175

f: 0141 248 6414

e: enquiries@sdf.org.uk

Edinburgh

139 Morrison Street, Edinburgh EH3 8AJ

t: 0131 221 9300

f: 0131 221 1556

e: enquiries@sdf.org.uk

www.sdf.org.uk

Find drug services in your area:

www.scottishdrugservices.com

Hepatitis Scotland:

www.hepatitisscotland.org.uk

Take Home Naloxone:

www.naloxone.org.uk

Copyright © Scottish Drugs Forum, Richard Hammersley, Phil Dalgarno 2013

All rights reserved ISBN 978-1-903483-10-7

Scottish Drugs Forum (SDF) www.sdf.org.uk is a company limited by guarantee, registration no. 106295 with charitable status and is also a registered Scottish charity registered SC 008075. Registered Office: 91 Mitchell Street, Glasgow, G1 3LN