A history of abuse: Documenting the harms experienced by the "Trainspotting generation"

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Abstract

The story of the past 40 years has been the relentless hollowing-out of industrial Britain leading to long-term unemployment and discarded generations that have been excluded socially and economically (Pearson 1987a, 1987b, Buchanan and Young 2000). In an attempt to block out these harsh social and economic realities of their lives, the youth of the 80s and 90s turned to heroin (Buchanan and Wyke 1987). By adopting a social harm approach to the analysis of semi-structured interviews with twelve opiate users (OUs), I argue that the problems often associated with drug use – experiences of stigmatisation, unemployment, and physical and mental health – might be best understood as harms resulting from a reductionist discourse that misrepresents drugs and drug users as a threat to society and focuses treatment on reducing the risks that OUs pose rather than enhancing the social resources necessary for human flourishing.

Key words

Drug use; addiction; social harm; stigmatisation; mental health

Resumen

La historia de los últimos 40 años ha sido el incesante desmantelamiento de la Gran Bretaña industrial hacia el desempleo de larga duración y las generaciones descartadas que han sido excluidas social y económicamente (Pearson 1987a, 1987b, Buchanan y Young 2000). En un intento de bloquear estas duras realidades sociales y económicas de sus vidas, los jóvenes de los 80 y los 90 recurrieron a la heroína (Buchanan y Wyke 1987). A partir de un abordaje de daño social para el análisis de entrevistas semiestructuradas con doce usuarios de opiáceos, aduzco que los problemas comúnmente asociados al consumo de drogas –experiencias de estigmatización, desempleo, y salud física y mental– podrían entenderse mejor como daños resultantes de un discurso reduccionista que representa erróneamente las drogas y a sus

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consumidores como una amenaza a la sociedad, y enfoca el tratamiento como una reducción de los daños que suponen los consumidores de opiáceos en lugar de enfocarlo en los recursos sociales que se necesitan para la prosperidad humana.

Palabras clave

Consumo de drogas; adicción; daño social; estigmatización; salud mental

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1. Introduction

The UK is currently amidst a drug-related deaths crisis. Of the deaths registered in 2017, 3,756 were due to drug poisonings – the highest since records began (Office for National Statistics 2018) – with over half (53%) involving opiates. While these figures are shocking, rather than situate them within a broader understanding of drug treatment policy, its development and implications for those attending treatment services, many of the explanations in circulation have been limited to the failing health and higher overdose risks of an older generation (40+) of long-term heroin users (O'Connor 2018).

While the "British system" of drug treatment has attracted much interest, with particular attention paid to the drug treatment policy of the last 40 years (Stimson 2000, Duke 2006, Reuter and Stevens 2008), commentators have tended to focus on the way in which the problems associated with drug use have been prioritised. Specifically, the priority afforded to reducing drug-related crime and the infrastructure put in place to address this have led some to suggest that drug treatment policy has become crime-focused (Stimson 2000, Hunt and Stevens 2004, Duke 2006, 2010, Stevens 2007, Seddon *et al.* 2008). Others have broadened this argument, suggesting that "since the mid 1960s, the drug problem has been recast as a matter of risk factors – whether in relation to the metaphorical 'socially infectious disease', a real contagious disease (HIV), or criminal victimisation – which need to be monitored, controlled and managed" and OUs (Opiate Users) have been viewed as sources of those risks (Seddon 2011, 417).

Relatively little attention has been paid to how the focus on risk, that is embedded within drug treatment policies, has impacted on the treatment experiences of OUs. Drawing on the definition of social harm put forward by Pemberton (2016), this paper seeks to address this deficit with specific attention being paid to those OUs that began their drug taking in the late 1980s and early 1990s. Drawing on semi-structured interviews with twelve OUs, this paper reframes the narrative by suggesting that the "problems" often associated with drug use – experiences of stigmatisation, unemployment, and physical and mental health – might be best understood as "harms" that have resulted from a reductionist discourse that misrepresents drugs and drug users as a threat to society and focused treatment on reducing the risks that OUs pose rather than enhancing the social resources necessary for human flourishing. Unable to link the experiences of OUs to the increase in drug-related deaths of recent years, setting out the experiences of OUs in this way nevertheless alludes to a complex picture of historical neglect that is worthy of further investigation.

In order to explore the ways in which a drug treatment policy that is focused on risk impacts on the lived experiences of OUs, I will begin by providing a capsule account of Pemberton's (2016) understanding of social harm. From here, I will draw attention to the reductionist discourse that has tended to dominate the development of drug treatment policy during the last thirty years. As I will show, at the centre of this discourse has been the process of "othering" where specific drugs and drug users have been misrepresented as a threat to society and become the scapegoats of modern time (Szasz 2003). Having documented the methods of data collection, in addition to situating and contextualising the study, I will turn to the findings to explore the iatrogenic harms experienced by OUs attending opiate substitute therapy (OST), an approach that has dominated drug treatment during the past 40 years.

2. Using "social harm" to identify the harms associated with drugs (treatment policy)

Used traditionally to expand the notions of crime, and in an attempt to broaden the boundaries of criminological enquiry, a social harm approach has been used to identify the harms associated with white-collar crimes (Sutherland 1945), human rights violations (Schwendingers 1970) and, more recently, harms that are "deleterious to people's welfare from the cradle to the grave" (Hillyard and Tombs 2004, 18). Earlier examples of social harms can be found in Engels' (1845/1987, 127) study of the industrial working class in Victorian England. Importantly for Pemberton (2016), Engels (1845/1987) understood that the harms visited upon the proletariat during this period were entirely preventable and a product of social relations that could be organised differently to meet the needs of the many and not just the few:

> When one individual inflicts bodily injury upon another, such injury that death results, we call the deed manslaughter; when the assailant knew in advance that the injury would be fatal, we call this deed murder. But when society places hundreds of proletarians in such a position that they inevitably meet a too early and unnatural death (…) when it deprives thousands of the necessities of life, places them under conditions in which they cannot live (…) forces them, through the strong arm of the law, to remain in such conditions until that death ensues which is the inevitable consequence – knows that these thousands of victims must perish, to remain in such conditions, its deed is murder just as surely as the deed of the single individual (…) which seem what it is, because no mad sees the murderer, because the death of the victim seems a natural one, since the offence is more one of omission than of commission. (Engels 1845/1987, 127)

While the story in contemporary times is slightly different, the relentless hollowing-out of industrial Britain during the past 40 years and mass long-term unemployment have led to the destabilisation of whole communities resulting in discarded generations that have been excluded socially and economically from the benefits widely available to those in work (Pearson 1987a, 1987b, Buchanan and Young 2000). The process of deindustrialisation during the 1980s affected the most labour-intensive industries and, for the first time in the post war period, a generation of school leavers who would otherwise have secured employment in apprenticeships, factories, shipyards and mines found themselves unemployed. Frequently labelled as the "Trainspotting generation", this discarded group of predominantly young men were excluded socially and economically from the benefits widely available to those in work (Pearson 1987a, 1987b, Buchanan and Young 2000) and it was within this environment that the youth of the 1980s turned to heroin in an attempt to block out the harsh social and economic realities of their lives (Pearson 1987a, 1987b, Buchanan and Wyke 1987).

It is for these reasons that a social harm approach to the understanding of how OUs have been not only presented but also treated might be appropriate. As alluded to earlier the treatment infrastructure, of which OST forms a large part, has been specifically designed to monitor, control and manage the so-called risks associated with drug use and OUs have been presented as sources of those risks (Seddon 2011). This approach has led some to suggest that drug treatment has been set up not necessarily for the benefit of drug users but for the benefit of the wider community by reducing so-called "drug-related crime" (McKeganey 2006).

Yet definitions of social harm have long been criticised for being ambiguous and confusing. Although Hillyard and Tombs (2004) identified fluid and ongoing categories of harm relating to physical, financial/economical, emotional/psychological and cultural safety, there still remained a lack of distinction between serious harms and personal hardships resulting in a concept of "social harm" that was difficult to pin down (Pemberton 2016, 18).

In an attempt to address some of these issues, Pemberton (2016) draws on Yar (2012, 63) by accepting the need to develop a framework that identifies social harms that "emanate from the actions and inactions of humans (individually and collectively)". In so doing, he suggests that "integral to the notion of social harm is an attempt to capture actions, practices and processes that have a significant impact on life chances" (Pemberton 2016, 27). In other words, if harm is to be avoided, opportunities to fulfil human needs through "self-actualisation" and "social participation" must be provided for. The non-fulfilment of specific needs, therefore, may result in identifiable categories of harms relating to the physical/mental health of individuals, their autonomy (particularly in terms their ability to formulate choice and have the capacity to act on these) and their ability to form relationships and engage in meaningful social networks (Pemberton 2016, 29).

Through this lens, the analysis presented in this paper reframes the "problems" typically associated with drug use as "harms" and in doing so captures the way in which these harms are produced. Furthermore, and to support Pemberton's own analysis of how contemporary capitalist societies jeopardise human flourishing, this paper will emphasise that in any analysis of social harm there is a need to consider the political and media narratives that are developed to support the implementation of particular forms of policy and practice. Of specific interest is the way in which these narratives and implementation of policy and practice coincide in ways that produce harms albeit, perhaps, unintentional.

3. Situating the treatment experiences of OUs: Negative portrayals and contempt within drug treatment policy

Refusing to acknowledge the structural causes of the 80s 'drug problem' alluded to earlier, the UK government instead recast drugs as a risk factor portraying young heroin addicts as unkempt social outcasts who threatened the cohesion of local communities and placed lives at risk. At this point, two groups emerged: one group, largely made up of unemployed working-class youth who lived on council estates, were seen as social deviants heavily involved in drugs and crime and causing havoc in communities; the other group consisted of respectable youth who were at risk of being lured into drug addiction by evil drug pushers (Buchanan and Wyke 1987).

Simultaneously, concerns were rising about the spread of HIV infection and the potential that injecting drug users might serve as a bridge for infection to the general population (Berridge 1996). The Advisory Council for the Misuse of Drugs (ACMD) asserted that AIDS was a greater threat to public health than drug misuse and that preventing the spread of HIV among injecting drug users accorded more importance than curing them of their addiction (Department of Health and Social Services 1988). In order to encourage drug users into services, community-based agencies were provided with a prescribing capability and OST became more readily available. It was within this climate that

abstinence from drugs became only an endpoint in a hierarchy of legitimate and acceptable goals with the aim to reduce the harm associated with drug use re-emerging as a primary treatment function.

During the 1990s, as the HIV/AIDS related health concerns began to recede, the twin issues of community safety and crime prevention emerged altering significantly the directional flow of policy away from the public health priorities of the previous decade. The 'drug problem' referred to during the 1980s was fast becoming a "crime problem" to policy makers and advisors. The ACMD (1991) suggested that, during 1987, approximately 3,600 heroin users were committing household burglary, 2,900 theft from the person and 5,000 shoplifting offence, and a review of literature on the links between drug use and crime found that the costs sustained by victims of drug-related crime were substantial, ranging from between £58 million and £864 million pounds (Stimson *et al.* 1990, Hough 1996).

It was within this climate that OUs became cast as "problematic". The original assertion by the ACMD (1982, 34) that the "problem drug user" was "any person who experiences social, psychological, physical, or legal problems relating to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances" provided for an holistic approach that acknowledged the social, psychological, physical and legal needs that OUs had. However, the definition of "problem drug user" provided during the late 1980s and 1990s focused on the social and economic costs associated with drug use, particularly with respect to the belief that much acquisitive crime was drug-related; in other words, was committed to finance drug use (Seddon 2011). Hence, the focus was no longer limited to the problems of drug users but on the potential harm they could cause to the wider community.

Rather than widening the approach used to treat OUs, the policy focus on the harms caused by them reinforced the use of OST as a way to manage and contain those problems. During the 1980s, 1990s and into the 2000s, OST and the ethos of harm reduction, management and maintenance, dominated the philosophy, purpose and practice of drug treatment. There were two reasons for this. The first, was that OST was hugely successful in lowering health risks by stabilising opiate intake as well as reducing the risks associated with intravenous administration. The second reason, and perhaps most controversial, was that OST was also successful in reducing the pressure on OUs to commit property crime in order to buy drugs.

The benefits of OST in terms of lowering health risks have been widely acknowledged. Compared to elsewhere in Europe, the UK avoided the rapid rise in HIV and HIV remained rare among injecting drug users (WHO Collaborative Study Group 1993). The National Treatment Outcomes Research Study (NTORS) found that treatment, of which OST formed a major part at the time of the study, worked and could produce significant and cost-effective reductions in harms to the patient and society (Gossop 2015). Similarly, record linkage studies in the UK and elsewhere have consistently shown that OST reduces clients' risk of drug-related death by half for those with a history of injecting (Pierce *et al.* 2016) and the longer an individual is on OST the greater the chances of reducing mortality among OUs (Cornish *et al.* 2010).

OST has also proven successful in reducing offending behaviour. Studies in Australia and Canada have found significantly lower offending rates during periods in which

individuals were attending methadone treatment than during periods without treatment (Lind *et al.* 2005, Russolillo *et al.* 2018). Although similar findings have been reported in the UK, the general consensus is that lower offending rates are reported for those in continuous treatment (Gossop *et al.* 2005, Millar *et al.* 2008, Millar and Webb 2019).

However, OST has long been criticised both for its function to "contain addicts" (Rosenbaum 1997) and for its function as a regulatory technology that aims to create productive and obedient subjects (Bourgois 2000, Friedman and Alicea 2001, Bull 2008, Fraser and Valentine 2008). Friedman and Alicea (2001) and Bourgois (2000, 165) both argue that OST has been used to produce docile bodies, to control "unruly misuses of pleasure" and reform "unproductive bodies". In particular, Bourgois (2000) illustrates the debilitating effects of OST documenting negative impacts on self-esteem and the collapse of relationships among OST clients. Making reference to indicators of socio-economic disadvantage, such as the high rates of unemployment and low income commonly associated with the drug treatment population (Jones *et al.* 2007), Bacon and Seddon (2019) also suggest that drug treatment has become another tool to regulate the poor. Moreover, OST has been criticised for "parking" patients by inner city pharmacists that are tasked with supervising consumption (Bryan 2013).

I have argued elsewhere the influence and constraints of a risk-based agenda on the everyday work of the drug treatment practitioner (Weston 2016, 15). Here, I illustrated how the

> focus of drug policy to break the so-called drugs-crime link and promote greater involvement of the criminal justice system in controlling drug use constrained the practice of drugs 'work' (…) in such a way that the fragmented and disjointed services previously identified in the sector and the need to address the complex needs of drug users remained significant challenges. (Weston 2016, 15)

Extending this argument, the aim of this paper is to explore the ways in which such a drug treatment policy impacts on the day to day lives of OUs. The aim of this paper is not to suggest that OST does not have its place in drug treatment, nor is it to deny its potential as a life-saving treatment, but rather to emphasise that the reductionist discourse that misrepresents drugs and drug users as a threat to society has focused treatment on reducing the risks that OUs pose rather than enhancing those social resources necessary for human flourishing.

Adopting the social harm approach advocated by Pemberton (2016, 24), that "social harm acts as shorthand to reflect the relations, processes, flows, practices, discourse, actions and inactions that constitute the fabric of our societies which serve to compromise the fulfilment of human needs and in doing so result in identifiable harms", this paper seeks to understand the lived experiences of those young people who began their drug taking in the late 1980s and early 1990s. Drawing on semi-structured interviews with twelve OUs, this paper illuminates the various harms that result when human flourishing is compromised through the denial of social resources necessary to ensure physical and mental integrity, a level of autonomy and a sense of connectedness with others. I argue that the negative consequences brought about by the broad umbrella of drug policy that adopts a framework of risk-based strategies designed to regulate and control OUs has focused on the social and economic costs associated with problem drug use while simultaneously overlooking the multiple and complex issues experienced by

this particular generation. Hence, the focus has not been on the harms suffered by drug users but on the harms that they cause leading to further experiences of stigmatisation, unemployment and enduring physical and mental health throughout the life course. Before grappling with these issues, it is first necessary to present a brief overview of the methods of data collection.

4. Research methods

The research presented in this paper draws on fieldwork conducted during 2009–2011 as part of an ESRC funded doctoral project. The key aim of this project was to understand the implications of drug treatment policy, that was underpinned by a framework of risk-based strategies to control drugs and drug users, on the treatment experiences of OUs.

The study adopted a longitudinal follow-up design of 16 OUs and their key workers, selected from across two towns in the North of England. The towns were selected according to their diversity in terms of degrees of urbanity and the range of services that were available to OUs. For both towns, access to drug treatment was made via GPs, self-referral, Criminal Justice interventions and from other services such as Needle Exchange. Clinical treatment, comprising OST, was the standard approach used to stabilising OUs across the two areas. As part of the overall system, both areas commissioned services to assist clients with housing needs, employability issues, general healthcare, benefits and financial advice, family support and a range of structured day care activities.

Participants were identified through the drug treatment service they were attending. Drug treatment workers were asked to approach all service users that were dependent on opiates to be involved in the research. Upon agreement, an interview was arranged at the time of their next appointment. Through this approach a total of 16 OUs were recruited. However, given the aims of this paper, the data presented focuses on the experiences of those OUs who were over the age of 30 at the time of interviewing and had first used opiates during the 1980s and 1990s.

All participants were interviewed using a semi-structured schedule at varying stages of their treatment and were followed up again between 6-18 months later. Demographic details were collected during the interviews (see Table 1 below) alongside discussions about their present circumstances, their drug using profile, information about their mental health, offending behaviour, and previous and present treatment experiences. Interviews were conducted at the treatment service from which the participants were recruited and lasted between 40 to 60 minutes. Ethical principles established in the code for research endorsed by the British Society of Criminology were adhered to and formal approval for the study was granted by the National Research Ethics Service (NRES), reference 07/Q1407/Q73. Approval from Research and Development was also gained from local Mental Health NHS Foundation Trusts.

TABLE 1

	Male		Female		All	
	N	%	N	%	N	%
Age 30+	6	50	6	50	12	100
White	6	50	4	67	10	83
Single	4	67	4	67	8	67
Unemployed	4	67	6	100	10	83
Accommodation						
Rented	4	67	5	83	9	75
NFA			1	17	1	1
Supported housing	2	33			2	17
Left school <=16 years	6	100	6	100	12	100
Previous treatment experience	6	100	6	100	12	100

Table 1. Participant demographics.

On completion and transcription of the interviews, the task was to read through the interview transcripts, becoming familiar with the content, and looking for interesting patterns and concepts that may help make sense of the data. The broad principles of grounded theory were followed throughout the process of data analysis (see Glaser and Strauss 1967, Strauss and Corbin 1990) and involved identifying themes and subthemes. Interview transcripts were considered alongside each other in order to compare and contrast the themes identified and to help determine the dominant themes that ran throughout the data. The process of coding was a recurrent one and resulted in the evolution and emergence of further concepts and themes. Following the principles of grounded theory, axial encoding was conducted during and throughout, enabling a process of iterative and dynamic data analysis (Ralph *et al.* 2015).

5. Thematic analysis: The relational, autonomous, physical and mental health harms experienced by OUs receiving OST

Having outlined the political and policy context for the study and articulated the methods utilised, in this section I elaborate three key themes which emerged from the data analysis. Drawing on Pemberton's (2016) approach, these themes illustrate the various harms that have resulted from a drug treatment policy that has failed to address the stigmatisation and the entrenched underlying multiple and complex issues presented by OUs. Focusing on the risks that OUs pose rather than on the issues presented by them has promoted a form of treatment and governance that, while successful in reducing blood borne viruses and so-called "drug-related" crime, has denied resources that have been necessary to ensure physical and mental integrity, a level of autonomy (in terms of facilitating the ability to make choices and being able to act upon these) and a sense of connectedness with others (in terms of facilitating the engagement in meaningful relationships and social networks).

Having presented the data, I will then offer some critical reflections on current policy and practice which might help to explain the presence of the harms observed. Where

extracts from interviews are presented – and consistent with ethical protocol – pseudonyms have been used to protect the identity of participants.

5.1. "They think I'm a smack head": The relational harms experienced by OUs

While drug use crosses all social demographics (Buchanan 2006) the images that are generated from drug policy and the mainstream news media do not adequately represent this. The negative and stereotypical representations of drug users (particularly heroin and crack cocaine users) as criminal outsiders and a threat to middle class sobriety and the fabric of mainstream society, are common features of government rhetoric and media reporting. This discourse, dominated by fear, has led to an "underlying strategy concerned with the punishment, control, and exclusion of drug users, rather than care, rehabilitation and inclusion", resulting in "widespread discrimination so that in addition to overcoming a drug problem, one of the biggest hurdles problem drug users face is breaking through the barrier of social exclusion, prejudice and discrimination" (Buchanan 2004, 394).

For the participants of this study, this type of relational harm manifested in experiences of discrimination and exclusion from their families, local communities and GPs. Both Reece and Jim described the rejection they experienced from their family:

> My family have all turned on me because they found out I've used again. They don't understand that I've had problems, they just see the bad things straight away, like you've took drugs again, you know, they don't understand. (Reece, age 30, follow-up)

> I just lost it all through drugs really. It cost me my family relationships, it's messed my life up you know, it's cost me quite dearly. (Jim, age 60)

These reflections illustrate the regret Reece and Jim have about their drug taking, particularly in terms of the impact on their relationships with their family. While Jim holds the "drugs" responsible for the breakdown of his relationships, Reece points towards his family's lack of understanding about the "problems" he was having. Present within both of these reflections are individualised explanations with little to no acknowledgement about the structural causes that may help to explain their drug use. This narrative, of course, reflects the political discourse surrounding drug taking and articulated earlier in this paper, that the problems of OUs result from an individual's addictive life choices.

Participants also described experiences of exclusion from their local communities. Labelled as "smack heads", a term that was used widely during the 1980s by tabloid newspapers (Buchanan 2015), Kevin and Reece reflected on how they felt "hated" by their local communities:

> [S]ometimes I don't want to go out of the house, I think oh I can't be arsed with all the kids hassling me, you know what teenagers are like nowadays, especially how I used to look and all, it's expected I suppose when they throw empty cans at me and call me a smack head. (Kevin, age 40)

> [I]f I went back there [home to girlfriend and son] with all the intentions of being a good man and trying I just know I couldn't because round there it's just a little town and all my friends are druggies and all the other people hate me because they think I'm a smack head. (Reece, age 30)

Common in these reflections are the way in which these experiences of stigmatisation become internalised. For example, Kevin suggested that he deserved to be treated in such a way while Reece described how he could not be "a good man" because everyone knows him as a "smack head".

Further experiences of discrimination came from GP surgeries. In the extract below, Wayne reported being wrongly accused of stealing a prescription from his GP resulting in an altercation between him and staff working in the surgery and ultimately him being removed from his GP's register:

> Well the one that I had before, they accused me of taking a form, they had me arrested for it and it wasn't me who did, I wouldn't do that, anyway they took me down four times to the bloody police station, and then oh I'm sorry Mr XX it wasn't you, and then they just kicked me off. I should be on warfarin, I've not had my warfarin for god knows how long, I've got emphysema (...), I should have dihydrocodeine for the pain in my legs, I should have inhalers for emphysema, asthma (...) I'm having to borrow one of my mum's inhalers. (Wayne, age 39)

Illuminated in these data are the complex ways in which the relational harms experienced by OUs connect with the physical and mental health harms also experienced by them. For Wayne, the experience of stigmatisation from his GP impacted physical health. Having been removed from his GP's register Wayne was unable to acquire his much-needed medication for his emphysema and deep vein thrombosis.

In fear of being further victimised Reece and Kevin also described feelings of social withdrawal, isolating themselves from those they cared about most:

> I went to jail and I just thought I'd had enough now. I rang my partner and I said look, I'll understand if you want to get on with your life, because I love her more than anything, she's my world, I still love her now but I can't live there and hurt her, I can't be a person that's hurting someone that I love so I said, look, it might be better if you just get on with your life and I'll just leave you to it. (Reece, age 30)

Not only do these data reveal the experiences of stigmatisation by OUs but emphasises the cumulative effects brought on by such encounters. Documented amongst the harms associated with these experiences were a loss of self-confidence, growing self-doubt and concerns about how others might react leading them to change their behaviour and unable to participate socially. During interviews a number of examples were uncovered of OUs choosing not to do certain things in fear of how other people might react. For Jon and Cara, even going about their daily business such as shopping became difficult:

> I'm not really getting any better in that respect, I just learn how to avoid it, how to avoid the situations but I can't really function normally in life because I can't go shopping and things like that. I have to go shopping at daft hours in the morning, when the supermarket's quiet or I have to go, it always has to be with people I know and I can't just go and do things that I want to do or go places. (Jon, age 33)

> [A]nxiety, I feel like I get panicky when I go out, some weeks I can't even go shopping, I have to ask my mum to do it for me, I just have to make an excuse that I feel ill or something and, the depression, I feel as if people will look at me when I go out, just not the same, I don't wear the clothes I used to wear, I don't dress up anymore, I don't go out, you know, it's not nice. (Cara, age 22)

Unable to engage socially and avoiding painful situations, Jon and Cara described how they were no longer able to function "normally". These examples are particularly concerning given the widely acknowledged benefits of social capital (Bourdieu 1985, Coleman 1988, Putnam 1995) and the consensus in the literature that "relationships matter" (Field 2003, 1). In terms of recovery from drug addiction, belonging to one or more social networks has been identified as supportive of recovery (Best and Laudet 2010, Terrion 2013, Weston *et al.* 2018) and results in better treatment outcomes (Zywiak *et al.* 2009, Panebianco *et al.* 2015). Yet the situations described here do not allow for the generation of capital, particularly the types of "bridging" and "linking" capital that are generated from the association with neighbourhood institutions and other individuals that have greater access to resources such as services and employment opportunities (Putnam 1995, 2000, Woolcock 2001).

5.2. "The only job I will get is… mopping toilets": The autonomous harms experienced by OUs

Unable to generate the "bridging" and "linking" capital necessary to access education and employment opportunities, a number of autonomy harms were described by participants. According to Pemberton (2016, 29) autonomy harms result from situations where people experience "fundamental disablement" in relation to their attempts to achieve self-actualisation, particularly in situations where there exists a lack of opportunity to engage in meaningful and productive work of their own choosing. Thus, in the absence of effective education and aspirational employment opportunities, as described by Kevin below, an ability to lead lives of one's own choosing remains severely compromised.

> I just hate being on the social, I hate it, but the more gear you do the more sort of paranoid you get and the less you want to interact with people, it puts you off from going on courses or applying for a job because you think, well I haven't worked for so long, I've got a criminal record, I'm an ex user. Nobody's going to touch you, are they? The only job I will get is basic like run of the mill sweeping up of a warehouse floor something, you know, mopping toilets. I don't want to be doing something like that. I want to get a wage in my hand, feel proud, I earned that money. (Kevin, age 40)

Kevin's reflection identifies the cyclical and intertwining nature of the harms experienced by OUs. As he describes, the longer he was involved in drug use, the less likely he was to interact with people and the less likely he was to do the things necessary that would allow him to access meaningful employment. The cyclical nature and cumulative harms described by Kevin were also echoed by Wayne:

> Well, that's all I've known all my life, the heroin, you just don't give a shit, and the diazies, they just chill you out, and you can think about how to get some money. Without the drugs all I can think about is that I'm gonna be £80 a week down in eight weeks time, I'm not gonna be able to live. We're gonna get our house taken off us. There's just no way we're gonna be able to live, the drugs, they take all that worry away. (Wayne)

Unable to work, due to his health, raised a number of monetary concerns that Wayne addressed with the use of drugs. Ironically then, and in contrast to the narrative produced in UK drug policy, the use of drugs became a solution to Wayne's problems rather than a cause. Strongly aligning to research on lay perspectives of social

determinants of health (Smith and Anderson 2017), this finding points towards the importance of "upstream" policies such as, in this example, supportive employment policies that might allow Wayne to earn an income rather than the singular policy solutions that focus on changing a person's behaviour (in this instance reducing drug consumption).

It is well established that the stigmatisation experienced by OUs, alongside poor educational attainment, act as barriers to finding and maintaining meaningful employment (Sutton *et al.* 2004, Spencer *et al.* 2008). Yet, as "employment is unlikely to be a priority for dependent drug users until they feel physically and mentally well, until they have a secure home to return to at the end of the day, and until their daily routines are not constantly interrupted by the urgency of taking more drugs" (Kemp and Neale 2005, 41), it is imperative that the entrenched problems brought about through stigmatisation and the cumulative effects of these encounters are addressed first and foremost.

5.3. "I've been here for nearly three years and I'm no better": The physical and mental health harms experienced by OUs

Adopting Doyal and Gough's (1991) human flourishing approach, Pemberton (2016) argues that individuals are said to experience harm in terms of their physical and mental wellbeing when their social relationships are undermined and/or they lack autonomy. As I have documented here, OUs experience harms both in terms of their social relationships and autonomy. In particular, the impact of stigmatisation on the OUs participating in this study was wide-ranging. As Wayne described, his physical health and quality of life became severely compromised through not being able to access his much-needed medication. As he articulated, his health prevented him from working and subsequently his ability to engage in an "active and successful life" (Pemberton 2016, 28).

> I'm having to borrow off Peter to pay Paul, it's really, really hard. I can't work, with my legs, I just can't do it. (Wayne, age 40, follow-up)

In terms of mental health harms, Pemberton (2016) identifies a range of illnesses and conditions ranging from severe personality and psychotic disorders through to depression and anxiety that may have resulted from uncertainty, feelings of helplessness and worthlessness. While some of the OUs participating in this study had experienced personality and psychotic disorders, the majority consistently expressed feelings of shame, guilt and low self-esteem:

> It was horrible, I used to hate it, I'd look in the mirror and smash it up because you're just a machine, it's just disgusting. (Reece, age 30)

Suicide attempts were also common among the experiences of participants:

> I've been referred to a psychiatrist in 2005, I tried to kill myself by injecting four bags of heroin and two £20 stones at once, I lost consciousness and everything but they brought me back around and put me in hospital (Jamie, age 29)

Yet, services to address these issues were not forthcoming. Jon, who reported having suffered from depression and anxiety since his early teens, described how his drug worker was unable to help him with his mental ill health:

> [My drug worker] says they can't really access anything like that, I've got to do it through my GP. (Jon, age 33)

Similarly, at her first interview, Adele described how she had previously received numerous episodes of OST – her latest one being a consequence of a Drug Rehabilitation Requirement she had been given 10 months previous – yet her depression remained a major concern of hers:

> I need to sort my depression out first, that's like my main focus but no one seems to be taking me seriously (…) I said I don't want to ask my Dr because I feel like I'm not going to get anywhere and she said, right, well, we'll see how you are on your methadone script because that might change your mood and then come and see me again. Anyway, I've been asking and asking and I still haven't had an appointment with the Dr there to see if they'll prescribe me them. (Adele, age 35)

At her follow-up interview 16 months later, very little had changed for Adele. Below she comments on how, despite being in OST for nearly three years, she was still suffering from depression and little had changed regarding her addiction:

> It's not so good, I suffer from depression anyway but it's getting worse. Well they've just been giving me my prescription basically and asking how are you going and poking their nose in (…) I've not had any benefit out of it at all. I've been here for nearly three years and I'm no better. (Adele, age 36, follow-up)

The relational and autonomous harms experienced by this group of OUs operate in rather complex ways, particularly when documenting the physical and mental health harms also experienced by them. It is widely acknowledged that OUs suffer from a range of physical and mental health issues. Weaver and colleagues (2003) found that 75% of drug service clients rated positive for at least one psychiatric disorder with the majority suffering from either personality disorder (37%), severe depression (27%) or severe anxiety (19%). Similarly, Sacks and Ries (2005, cited by Flynn and Brown 2008), reported that 50% to 70% of clients attending drug misuse treatment showed lifetime histories of mental health problems, and Watkins and colleagues (2004) screened admissions to three outpatient substance misuse treatment services and found that approximately 50% had co-occurring mental health disorders. The physical health problems of OUs have also long been recognised. Intake data from the National Treatment Outcome Research Study (Gossop *et al.* 1998) suggested that the majority of the cohort reported physical health problems ranging from sleep disturbance (81%), weight loss (68%) and chest pains (38%) and OUs have reported poorer overall physical health than that of the general population (Hser *et al.* 2004, Grella and Lovinger 2012). However, the data set out here suggest that when OUs are unable to participate in social relationships to gain access to much needed services, such as education and employment opportunities, the physical and mental health issues that might already be present are further exacerbated. In the absence of support to address these issues, some of the OUs interviewed began using opiates again despite being abstinent for several months.

In the extract below, Reece begins by describing his sense of optimism both in terms of his drug use and future aspirations. Like many of those I interviewed, Reece had previously received numerous episodes of treatment, the latest one being as a condition of a license upon his release from prison. At the time of his first interview, Reece was receiving a Buprenorphine prescription to relieve him of cravings for heroin and

generally expressed satisfaction with his treatment. He was also working part-time as a chef:

> It's like me, I'm on the subbies now and I'm happy, I'm on a small dose and it doesn't really affect my life, I can live a normal life you know and I do (…) I work part-time on a Sunday. Just as a chef on a Sunday, doing Sunday dinners and that. (Reece, age 30)

The support provided for his mental health problems, however, was more problematic. Reece had been referred to a psychiatric nurse several times with little success. At this first interview, he was waiting for an appointment from a psychiatrist who specialised in anxiety:

> [My drug workers] referred me to see this woman who I'm waiting to see who specialises in people who've had long term problems with anxiety and that (…) I just want to find something that helps with my anxiety so I can sleep properly at night and stuff and be relaxed and not feel scared all the time, and that's it. (Reece, age 30)

Yet, at his follow-up interview six months later, Reece's mental health remained unresolved and he began using opiates again:

> I was really happy with the help I was getting when I was on licence and coming here, doing groups and everything, it really helped me, that's why I was doing so well because of all the help I had around (…) it all sort of stopped at once, so I sort of ended up on my own, you know, it sort of all hit me (…). After my license ended I just started getting so I couldn't go out and started getting panicky about going anywhere and it just hit me bad. It was really bad, I couldn't eat, I was depressed one minute and be all right the next but I'd still be anxious. It just really hit me bad (…) I started drinking a little bit and stuff to try and relax, that's why I took a bit of drugs, you know, because I was drinking and I couldn't relax, things like that. (Reece, follow-up, age 30)

Illustrating the potentially damaging effects of having unresolved mental health issues, these reflections reveal the vulnerability of OUs even when attending treatment. While relapse is common among OUs (Gossop *et al.* 2002), it is widely acknowledged that factors such as negative mood states (Hammerbacher and Lyvers 2009) and co-occurring psychiatric diagnosis such as anxiety and depression (Andersson *et al.* 2019) are predictors of relapse. Despite this long-standing acknowledgement, the data revealed here suggest that the mental health of OUs is both under-recognised and inadequately treated.

6. Discussion

The harms experienced by OUs are both complex and intertwined. While I have identified specific harms under the headings relational, autonomous, physical and mental health, the complexity and the way in which these harms connect to one another cannot be overstated. Drawing on the experiences of OUs I have illustrated how the inability to maintain social relationships necessary to access much needed services and exercise life choices have impacted on the physical and mental health of my participants. Simultaneously, it was clear that the physical and mental health issues identified by those interviewed compromised their ability to make life choices and maintain social relationships.

In documenting the harms experienced by OUs, the way in which they are produced has also been captured. The exacerbating effect of stigmatisation on the three main categories

of harms experienced by the participants of this study has not been previously attended to in sufficient detail. While Pemberton (2016) acknowledges the way in which stigma may cause individuals to withdraw from social relationships and erode self-esteem, the extent to which it forms part of the harm producing process is not made clear. Documenting the development of the drug treatment policy narrative and subsequent practice of the last 30 years has illustrated how, in the name of public health and crime reduction, OUs have been unable to socially participate successfully, particularly in terms of generating the capital necessary for human flourishing (Doyal and Gough 1991). Specifically, I have illustrated how the stigmatisation and the cumulative effects of these experiences are potentially deleterious impacts of the late twentieth century neoliberal turn in drug policy that focuses on the risks that OUs pose rather than on their lived experiences. The official discourse surrounding drug use, situated within both policy and the media, operates within a vaccum that constructs the OU as someone to be feared and furthermore "architects of their own demise". For example, users of illicit drugs are often viewed as "less deserving because their need results from addictive life choices rather than the perils of random health failure" (Simmonds and Coomber 2009, 125). This was certainly the view of David Cameron, former Prime Minister, who reported that:

> We are finding a large number of people who are on incapacity benefit through drug problems, alcohol problems and problems with weight and diet, and I think a lot of people who pay their taxes and work hard will think that's not what I pay my taxes for, I pay my taxes for people who are incapacitated through no fault of their own. (David Cameron, cited in BBC News 2011)

It is also this type of discourse that promotes a form of treatment and governance that, while successful in reducing blood borne viruses (WHO Collaborative Study Group 1993) and so-called "drug-related" crime (Gossop *et al.* 2005, Millar *et al.* 2008, Millar and Webb 2019), does not address the stigmatisation and entrenched multiple and complex issues experienced by OUs. This finding is consistent with those of the Drug Treatment Outcomes Research Study, which reported substantial reductions in drug use, crime and risk to health but very few gains in employment and housing (Jones *et al.* 2009). At follow-up, just under a fifth recalled receiving employment-related help from any source, let alone the treatment service itself. Not surprisingly, little progress was made in gaining paid employment and little too in laying the foundations for employment in improved mental health. Similarly, drawing on data collected from focus groups with service users, Revolving Doors (2010, 4) argue that "drug workers only assess and address drug needs, in particular methadone provision, without taking into consideration other support needs".

To echo suggestions made by Pemberton (2016, 154), the types of harms I have documented here may only be "part of the story. The remainder of the story is yet to be told, documenting the collateral injuries and human misery of [the programme of austerity]". Like other areas of adult social care, drug treatment did not escape the injurious cuts in funding that have been undertaken since 2010. Aligning with their broader plan to reduce public expenditure, the UK Coalition government implemented their new drug strategy that had a renewed focus on supporting people to become free from their dependence (HM Government 2010). As with previous strategies the rhetoric that OUs pose a risk, this time in relation to the economy and the cost of OST, remained

(Seddon *et al.* 2012). Moreover, the strategy has done very little in terms of support for mental health and social care (Webster 2015) particularly since it is these very services that have borne the brunt of austerity measures (Kamal 2019). In an analysis of official documents and ministerial speeches on recent drug policy, Stevens (2019, 448) extends this argument suggesting that the resentment towards some sections of the working classes that is found within government discourse has led to a failure to provide effective services to save the lives of such groups – including those working classes who use heroin.

Therefore, returning to the point I made at the beginning of this paper, the links that have been previously identified between the harms documented here and premature mortality must not be overlooked. As indicated earlier, explanations for the drug-related death crisis observed in recent years have been limited to the failing health and higher overdose risks of an older generation (O'Connor 2018) with recommendations made to manage the complex health needs of older opiate users (Pierce *et al.* 2016, 2018). Yet, the findings of this paper allude to a much more complex picture of historical neglect that is worthy of further investigation. Recent evidence suggests that the negative discursive constructions of drug users has led to the recent state inertia to invest in services that will reduce drug-related deaths (Stevens 2019); an inertia that has come about because these lives are either considered not "grievable" (Butler 2016) or "los-able" (Fraser *et al.* 2018). To complement this finding, I have identified the consequences of these constructions on issues that have operated in the past but that may have had a lasting effect on the present. It has been recognised that "social relationships, or the relative lack thereof, constitute a major risk factor for health – rivalling the effect of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity" (House *et al.* 1988, 541). In a more recent meta-analytic review of mortality risk, researchers concluded that individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships (Holt-Lumstad *et al.* 2010). Additionally, poor mental health has been associated with premature mortality. Druss and collaborators (2011) found that people with mental disorders die eight years earlier on average than people without such disorders. Similarly, the World Health Organisation (2015) reported that people with severe mental illness died 25 years earlier on average than the general population. Given this evidence, the extent to which the relational and mental health harms experienced by OUs have contributed to their risk of mortality in recent years needs further consideration.

As Kalk and collaborators (2017) suggest, there is much to be learned from the history of opiate treatment in the UK. Adopting a social harm approach in the analysis of interviews with OUs has allowed the "problems" traditionally associated with drug use to be reframed as "harms" that have resulted from a reductionist discourse that misrepresents drugs and drug users as a threat to society. Therefore, not only have the various harms experienced by OUs attending OST been identified, but the way in which they are produced has also been captured. I have no intention in this paper to criticise the British system of drug treatment nor am I denying its potential as a life-saving treatment. However, as researchers within this field of enquiry we must ask ourselves whether we are satisfied with a system that adopts an essentially utilitarian approach to the treatment of drug use. The focus within drug treatment for the past thirty years or

so to reduce the risks associated with drug use has, without doubt, been successful in lowering the health risks associated with intravenous administration as well as reducing the pressure on OUs to commit property crime. What I am suggesting though is that while this system has been *harm reducing* across a number of key domains, through the negative political and media discourse surrounding drug use and by focusing on the risks that OUs pose rather than enhancing the social resources necessary for human flourishing, it has nevertheless been simultaneously *harm producing.*

References

Advisory Council on the Misuse of Drugs, 1982. *Treatment and Rehabilitation*. London: HMSO.

Advisory Council on the Misuse of Drugs, 1991. *Drug Misusers and the Criminal Justice System Part 1: Community Resources and the Probation Service*. London: HMSO.

Andersson, H., Wenaas, M., and Nordfjaern, T., 2019. Relapse after inpatient substance use treatment: A prospective cohort study among users of illicit substances. *Addictive Behaviours* [online], 90, 222–228. Available from: https://doi.org/10.1016/j.addbeh.2018.11.008 [Access 23 September 2020].

Bacon, M., and Seddon, T., 2019. Controlling drug users: Forms of power and behavioural regulation in drug treatment services. *The British Journal of Criminology* [online], 60(2). Available from: https://doi.org/10.1093/bjc/azz055 [Access 23 September 2020].

BBC News, 2011. PM vows action to get addicts on benefits into work. *BBC News* [online], 21 April. Available from: https://www.bbc.com/news/uk-politics-13152349 [Access 3 May 2011].

Berridge, V., 1996. *AIDS in the UK: The Making of a Policy, 1981–1994.* Oxford University Press.

Best, D., and Laudet, A.B., 2010. *The potential of recovery capital* [online]. London: The RSA. Available from: https://www.thersa.org/globalassets/pdfs/blogs/a4-recovery-capital-230710-v5.pdf [Access 23 September 2020].

Bourdieu, P., 1985. The Forms of Capital. *In:* J.G. Richardson, ed., *Handbook of Theory and Research for the Sociology of Education.* New York: Greenwood.

Bourgois, P., 2000. Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry* [online], 24, 165–195. Available from: https://doi.org/10.1023/A:1005574918294 [Access 23 September 2020].

Bryan, J., 2013. Methadone may not be the perfect drug but it has helped many drug addicts. *The Pharmaceutical Journal* [online], 16 October. Available from: https://www.pharmaceutical-journal.com/news-and-analysis/methadone-may-not-be-the-perfect-drug-but-it-has-helped-many-drug-addicts/11128731.article?firstPass=false [Access 23 September 2020].

Buchanan, J., 2004. Missing links? Problem drug users and social exclusion. *Probation Journal* [online], 51(4), 387–397. Available from: https://doi.org/10.1177/0264550504048246 [Access 23 September 2020].

Buchanan, J., 2006. Understanding Problematic Drug Use: A Medical Matter or a Social Issue? *British Journal of Community Justice*, 4(2), 387–397.

Buchanan, J., 2015. Ending drug prohibition with a hangover? *British Journal of Community Justice,* 15(1), 55–74.

Buchanan, J., and Wyke, G., 1987. *Drug Use and Its Implications: A Study of the Sefton Probation Area.* Waterloo: Merseyside Probation Service.

Buchanan, J., and Young, L., 2000. The War on Drugs – A War on Drug Users? *Drugs: Education, Prevention and Policy* [online], 7(4), 409–422. Available from: https://doi.org/10.1080/dep.7.4.409.422 [Access 23 September 2020].

Bull, M., 2008. *Governing the Heroin Trade: From Treaties to Treatment.* Aldershot: Ashgate.

Butler, J., 2016. *Frames of War: When is Life Grievable?* New York: Verso.

Coleman, J., 1988. Social Capital in the creation of human capital. *American Journal of Sociology* [online], 94(1), 95–121. Available from: https://doi.org/10.1086/228943 [Access 23 September 2020].

Cornish, R., *et al.*, 2010. Risk of death during and after opiate substitution treatment in primary care: Prospective observational study in UK General Practice Research Database. *The British Medical Journal* [online], 341. Available from: https://doi.org/10.1136/bmj.c5475 [Access 23 September 2020].

Department of Health and Social Services, 1988. *Models of general practitioner involvement in working with misusers. Health Circular 88/53.* London: Department of Health.

Doyal, L., and Gough, I., 1991. *A Theory of Human Need.* Basingstoke: Palgrave Macmillan.

Druss, B., *et al.*, 2011. Understanding excess mortality in persons with mental illness: 17 year follow up of a nationally representative US survey. *Medical Care* [online], 49(6), 599–604. Available from: https://doi.org/10.1097/MLR.0b013e31820bf86e [Access 23 September 2020].

Duke, K., 2006. Out of crime and into treatment?: The criminalization of contemporary drug policy since Tackling Drugs Together. *Drugs: Education, Prevention and Policy* [online], 13(5), 409–415. Available from: https://doi.org/10.1080/09687630600613520 [Access 23 September 2020].

Duke, K., 2010. Clashes in Culture? The professionalization and criminalization of the drugs workforce. *British Journal of Community Justice*, Special Edition, 8(2), 31–43.

Engels, F., 1987. *The Condition of the Working Class in England.* Harmondsworth: Penguin. (Originally published in 1845).

Field, J., 2003. *Social Capital*. London: Routledge.

Flynn, P.M., and Brown, B.S., 2008. Co-occurring disorders in substance abuse treatment: Issues and prospects. *Journal of Substance Abuse Treatment* [online], 34(1), 36–47. Available from: https://doi.org/10.1016/j.jsat.2006.11.013 [Access 23 September 2020].

Fraser, S., and Valentine, K., 2008. *Substance and Substitution: Methadone Subjects in Liberal Societies.* New York: Palgrave Macmillan.

Fraser, S., Farrugia, A. and Dwyer, R., 2018. Grievable lives? Death by opioid overdose in Australian newspaper coverage. *The International Journal of Drug Treatment Policy* [online], 59, 28–35. Available from: https://doi.org/10.1016/j.drugpo.2018.06.004 [Access 23 September 2020].

Friedman, J., and Alicea, M., 2001. *Surviving Heroin: Interviews with Women in Methadone Clinics.* Gainesville: University Press of Florida.

Glaser, B., and Strauss, A., 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

Gossop, M., 2015. The National Treatment Outcomes Research Study (NTORS) and its influence on addiction treatment policy in the United Kingdom. *Addiction* [online], 110(S2), 50–53. Available from: https://doi.org/10.1111/add.12906 [Access 23 September 2020].

Gossop, M., *et al.*, 2002. Factors associated with abstinence, lapse and or relapse to heroin use after residential treatment: protective effect of coping responses. *Addiction* [online], 97(10), 1259–67. Available from: https://doi.org/10.1046/j.1360-0443.2002.00227.x [Access 23 September 2020].

Gossop, M., *et al.*, 2005. Reductions in criminal convictions after addiction treatment: 5–year follow-up. *Drug and Alcohol Dependence* [online], 79(3), 295–302. Available from: https://doi.org/10.1016/j.drugalcdep.2005.01.023 [Access 23 September 2020].

Gossop, M., Marsden, J., and Stewart, D., 1998. *NTORS at one year. The National Treatment Outcomes Research Study. Changes in substance use, health and criminal behaviour at one after intake*. London: Department of Health.

Grella, C., and Lovinger, K., 2012. Gender differences in physical and mental health outcomes among an aging cohort of individuals with a history of heroin dependence. *Addictive Behaviours* [online], 37(3), 306–312. Available from: https://doi.org/10.1016/j.addbeh.2011.11.028 [Access 23 September 2020].

Hammerbacher, M., and Lyvers, M., 2009. Factors associated with relapse among clients in Australian substance disorder treatment facilities. *Journal of Substance Use* [online], 11(6), 387–394. Available from: https://doi.org/10.1080/14659890600708266 [Access 23 September 2020].

Hillyard, P., and Tombs, S., 2004. Beyond criminology? *In:* P. Hillyard *et al*., eds., *Beyond Criminology: Taking Harm Seriously.* London: Pluto Press.

HM Government, 2010. *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* [online]. London: Home Office. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf [Access 23 September 2020].

Holt-Lunstad, J., Smith, T., and Layton, J., 2010. Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* [online], 7(7). Available from: https://doi.org/10.1371/journal.pmed.1000316 [Access 23 September 2020].

Hough, M., 1996. *Drug Misusers and the Criminal Justice System: A Review of the Literature.* London: Home Office.

House, J., Landis, K., and Umberson, D., 1988. Social relationships and health. *Science* [online], 241(4865), 540–545. Available from: https://doi.org/10.1126/science.3399889 [Access 23 September 2020].

Hser, Y., *et al.,* 2004. Health conditions among aging narcotics addicts: Medical examination results. *Journal of Behavioural Medicine* [online], 27(6), 607–622. Available from: https://doi.org/10.1007/s10865-004-0005-x [Access 23 September 2020].

Hunt, N., and Stevens, A., 2004. Whose harm? Harm reduction and the shift to coercion in UK drug policy. *Social Policy and Society* [online], 3(4), 333–342. Available from: https://doi.org/10.1017/S1474746404001964 [Access 23 September 2020].

Jones, A., *et al*., 2007. *The Drug Treatment Outcomes Research Study (DTORS): Baseline Report.* London: Home Office.

Jones, A., *et al*., 2009. *The Drug Treatment Outcomes Research Study (DTORS): Final Outcomes Report.* London: Home Office.

Kalk, N., *et al*., 2017. Treatment and intervention for opiate dependence in the United Kingdom: Lessons from triumph and failure. *European Journal on Criminal Policy and Research* [online], 24(2), 183–200. Available from: https://doi.org/10.1007/s10610-017-9364-z [Access 23 September 2020].

Kamal, M., 2019. Austerity and the Damage Done: The Crisis in Mental Health Care. *Counterfire* [online], 18 February. Available from: https://www.counterfire.org/articles/opinion/20160-austerity-and-the-damage-done-the-crisis-in-mental-health-care [Access 1 October 2019].

Kemp, P.A., and Neale, J., 2005. Employability and problem drug users. *Critical Social Policy* [online], 25, 28–46. Available from: https://doi.org/10.1177/0261018305048966 [Access 23 September 2020].

Lind, B., *et al*., 2005. The effectiveness of methadone maintenance treatment in controlling crime: An Australian aggregate level analysis. *The British Journal of Criminology* [online], 45(2), 201–211. Available from: https://doi.org/10.1093/bjc/azh085 [Access 23 September 2020].

McKeganey, N., 2006. The lure and the loss of harm reduction in UK drug policy and practice, *Addiction Research and Theory* [online], 14(6), 557–588. https://doi.org/10.1080/16066350601002369 [Access 23 September 2020].

Millar, T., and Webb, R., 2019. Strong evidence indicating the effectiveness of opioid agonist treatment, *The Lancet Public Health* [online], 4(7), 314–315. Available from: https://doi.org/10.1016/S2468-2667(19)30100-8 [Access 23 September 2020].

Millar, T., *et al.*, 2008. *Changes in Offending following Prescribing Treatment for Drug Misuse* [online]. London: National Treatment Agency for Substance Misuse. Available from: https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/c/h/a/changes-in-offending-following-prescribing-treatment-for-drug-misuse.pdf [Access 23 September 2020].

O'Connor, R., 2018. Drug Misuse Deaths Fall but Still Remain Too High. (Blog post). *Public Health Matters* [online], 8 August. Available from: https://publichealthmatters.blog.gov.uk/2018/08/08/drug-misuse-deaths-fall-but-still-remain-too-high/ [Access 1 July 2019].

Office for National Statistics, 2018. *Deaths Related to Drug Poisoning in England and Wales: 2017 registrations* [online]. Newport/Titchfield/London: ONS. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations [Access 2 July 2019].

Panebianco, D., *et al.*, 2015. Personal support networks, social capital, and risk of relapse among individuals treated for substance use issues. *International Journal of Drug Policy* [online], 27, 146–153. Available from: http://dx.doi.org/10.1016/j.drugpo.2015.09.009 [Access 23 September 2020].

Pearson, G., 1987a. Social Deprivation, Unemployment and Patterns of Heroin Use. *In:* N. Dorn and N. South, eds., *A Land Fit for Heroin?* London: Macmillan.

Pearson, G., 1987b. *The New Heroin Users*. Oxford: Blackwell.

Pemberton, S., 2016. *Harmful Societies: Understanding Social Harm.* Bristol: Policy Press.

Pierce, M., *et al.*, 2016. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction* [online], 111(2), 298–308. Available from: https://doi.org/10.1111/add.13193 [Access 23 September 2020].

Pierce, M., *et al.*, 2018. Ageing opioid users' increased risk of methadone-specific death in the UK. *International Journal of Drug Policy* [online], 55, 121–127. Available from: https://doi.org/10.1016/j.drugpo.2018.02.005 [Access 23 September 2020].

Putnam, R., 1995. Bowling Alone: America's Declining Social Capital. *Journal of Democracy* [online], 6(1), 65–78. Available from: https://doi.org/10.1353/jod.1995.0002 [Access 23 September 2020].

Putnam, R.D., 2000. *Bowling Alone: The Collapse and Revival of American Community.* London: Simon & Schuster.

Ralph, N., Birks, M., and Chapman, Y., 2015. The Methodological Dynamism of Grounded Theory. *International Journal of Qualitative Methods* [online], 14, 1–6. Available from: https://doi.org/10.1177/1609406915611576 [Access 23 September 2020].

Reuter, P., and Stevens, A., 2008. Assessing UK Drug Policy from a Crime Control Perspective. *Criminology and Criminal Justice* [online], 8(4), 461–482. Available from: https://doi.org/10.1177/1748895808096473 [Access 23 September 2020].

Revolving Doors, 2010. *2010 Drugs Strategy Consultation: Revolving Doors Agency Response, 30 September 2010.* London: Revolving Doors.

Rosenbaum, M., 1997. The de-medicalization of methadone maintenance. *In:* P. Erickson *et al*., eds., *Harm Reduction*. University of Toronto Press.

Russolillo, A., *et al*., 2018. Associations between methadone maintenance treatment and crime: A 17-year longitudinal cohort study of Canadian provincial offenders. *Addiction* [online], 113(4), 656–667. Available from: https://doi.org/10.1111/add.14059 [Access 23 September 2020].

Schwendingers (The), H. and J., 1970. Defenders of order or guardians of human rights. *Issues in Criminology* [online], 5(2), 123–157. Available from: https://www.jstor.org/stable/42909616 [Access 23 September 2020].

Seddon, T., 2011. What is a problem drug user? *Addiction Research and Theory* [online], 19(4), 334–343. Available from: https://doi.org/10.3109/16066359.2010.512109 [Access 23 September 2020].

Seddon, T., Ralphs, R., and Williams, L., 2008. Risk, Security and the "Criminalization" of British Drug Policy. *British Journal of Criminology* [online], 48(6), 818–834. Available from: https://doi.org/10.1093/bjc/azn056 [Access 23 September 2020].

Seddon, T., Williams, L. and Ralphs, R., 2012. *Tough Choices: Risk, Security and the Criminalisation of Drug Policy.* Oxford University Press.

Simmonds, L., and Coomber, R., 2009. Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy* [online], 20(2), 121–130. Available from: https://doi.org/10.1016/j.drugpo.2007.09.002 [Access 23 September 2020].

Smith, K., and Anderson, R., 2017. Understanding lay perspectives on socioeconomic health inequalities in Britain: A meta ethnography. *Sociology of Health and Illness* [online], 40(1), 146–170. Available from: https://doi.org/10.1111/1467-9566.12629.

Spencer, J., *et al*., 2008. *Getting Problem Drug users (Back) Into Employment: Part Two* [online]. Evidence Review. December. London: UKDPC. Available from: https://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Getting%20problem%20drug%20users%20(back)%20into%20employment_%20employer,%20provider%20and%20service%20user%20perspectives.pdf [Access 23 September 2020].

Stevens, A., 2007. When two dark figures collide: Evidence and discourse on drug-related crime. *Critical Social Policy* [online], 27(1), 77–99. Available from: https://doi.org/10.1177/0261018307072208 [Access 23 September 2020].

Stevens, A., 2019. "Being human" and "moral sidestep" in drug policy: Explaining government inaction on opioid-related deaths in the UK. *Addicitve Behaviors* [online], 90, 444–450. Available from: https://doi.org/10.1016/j.addbeh.2018.08.036 [Access 23 September 2020].

Stimson, G., *et al*., 1990. Distributing sterile needles and syringes to people who inject drugs: the syringe exchange experiment. *In:* J. Strang and G. Stimson, eds., *Aids*

and Drug Misuse: The Challenges for Policy and Practice in the 1990s. London: Routledge.

Stimson, G.V., 2000. Blair Declares War: the unhealthy state of British drug policy. *International Journal on Drug Policy* [online], 11(4), 259–264. Available from: https://doi.org/10.1016/S0955-3959(00)00060-8 [Access 23 September 2020].

Strauss, A., and Corbin, J., 1990. *Basics of Grounded Theory Methods.* Beverly Hills: Sage.

Sutherland, E., 1945. Is "White Collar Crime" a Crime? *American Sociological Review* [online], 10(2), 132–139. Available from: https://doi.org/10.2307/2085628 [Access 23 September 2020].

Sutton, L., *et al.*, 2004. *Drug and alcohol use as barriers to employment: a review of the literature.* Report. Loughborough University, for Department for Work and Pensions.

Szasz, T., 2003. *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers.* Syracuse University Press.

Terrion, L.J., 2013. The experience of post-secondary education for students in recovery from addiction to drugs or alcohol: Relationships and recovery capital. *Journal of Social and Personal Relationships* [online], 30(1), 3–23. Available from: https://doi.org/10.1177/0265407512448276 [Access 23 September 2020].

Watkins, K.E., *et al.*, 2004. Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *Journal of Drug and Alcohol Abuse* [online], 30(4), 749–764. Available from: https://doi.org/10.1081/ADA-200037538 [Access 23 September 2020].

Weaver, T., *et al.*, 2003. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry* [online], 183(4), 304–313. Available from: https://doi.org/10.1192/bjp.183.4.304 [Access 23 September 2020].

Webster, R., 2015. *Is the Drug Strategy Working?* [online]. Blog post. 12 March. Available from: http://www.russellwebster.com/is-the-drug-strategy-working/ [Access 1 October 2019].

Weston, S., 2016. The everyday work of the drug treatment practitioner: The influence and constraints of a risk-based agenda. *Critical Social Policy* [online], 36(4), 511–530. Available from: https://doi.org/10.1177/0261018316632666 [Access 23 September 2020].

Weston, S., Honor, S., and Best, D., 2018. A tale of two towns: A comparative study exploring the possibilities and pitfalls of social capital among people seeking recovery from substance misuse. *Substance Use and Misuse* [online], 53(3). Available from: https://doi.org/10.1080/10826084.2017.1341925 [Access 23 September 2020].

Woolcock, M., 2001. *Using Social Capital: Getting the Social Relations Right in the Theory and Practice of Economic Development.* Princeton University Press.

World Health Organization Collaborative Study Group, 1993. An international comparative study of HIV prevalence and risk behaviour among drug injectors in 13 cities. *Bulletin on Narcotics,* XLV, 19.

World Health Organization, 2015. *Mental Health Atlas 2014* [online]. Available from: http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1. [Access 6 November 2019].

Yar, M., 2012. Critical criminology, critical theory and social harm. *In:* S. Hall and S. Winlow, eds., *New Directions in Criminological Theory,* Abingdon: Routledge.

Zywiak, W., *et al.,* 2009. The Important People drug and alcohol interview: Psychometric properties, predictive validity and implications for treatment. *Journal of Substance Abuse Treatment* [online], 36(3), 321–330. Available from: https://doi.org/10.1016/j.jsat.2008.08.001 [Access 23 September 2020].