CHAPTER 6

Social Reintegration and the Management of Stigma

Although the term 'social reintegration' is not used uniformly across countries, it is widely acknowledged as a key aspect of a full and successful recovery from drug dependence (EMCDDA, 2012). Social reintegration, defined as "any social intervention with the aim of integrating former or current problem drug users into the community" (EMCDDA, 2012: 28), is concerned with the position of the individual in wider society. Thus, while engagement in drug treatment is an essential step, the wider context within which treatment unfolds – including education and employment, housing and family relationships – must be considered and addressed (EMCDDA, 2012; Keane, 2007; Neale & Kemp, 2010).

This chapter seeks to extend understanding of the study participants' lives beyond MMT. It starts by discussing employment, which is a critical 'plank' of social reintegration (EMCDDA, 2012; Keane, 2007). The analysis then turns to housing, focusing on the impact of housing stability, housing precariousness and homelessness on participants' lives. Participants' relationships with family members and friends are examined, as well as what many depicted as a lives characterised by social isolation. The chapter concludes by examining stigma, which permeated the narratives of the study's participants, acting as a significant barrier to what is generally understood as 'social reintegration'.

Employment

Just three of the study's 25 participants, all women who worked full-time, were employed at the time of interview. The vast majority had worked in the past, although not for many years in most cases. Those who reported a history of labour market participation had typically worked in low-paid jobs, often on a casual basis, which meant that many did not have a formal employment record. The absence of an employment history, coupled with low levels of educational attainment, created significant barriers to labour market participation. Several articulated an awareness of their highly disadvantaged position when seeking employment because of their lack of formal educational qualifications.

> *" … you need like, you need certificates just to work in McDonald's now. Like that's how bad the job situation is that even they can say like, 'Ah well, you need your Junior Cert or whatever. I left school well before that, I don't have a CV or anything like."* (Richie, age 40-44)

"I don't have any education and they say even your Junior Cert won't get you a job now, you need a Leaving Cert." (Craig, age 35-39).

A range of additional barriers to seeking and gaining employment were discussed by respondents. Among these, the problem of having a criminal record was a frequently noted challenge with 13 of the study's male participants stating that their prior criminal record presented what seemed, to at least a number, like an insurmountable obstacle in seeking employment.

"I sent CVs out and all but most of them are looking for this Garda vetting. And then once the Guards say, 'Yeah, he's been in trouble' … but it's been seven or eight years ago, I think it could be longer now but I'm not really sure at the moment. But that wouldn't look good." (Tommy, age 40-44)

"Well when you're filling in forms, CVs and that, they do ask questions like criminal records. It was like, should I? I did have some, they weren't burglaries or robberies or things like that, they were just like, stupid things, really." (Danny, age 40-44)

The demands associated with a daily routine of MMT – in terms of maintaining clinic and/or pharmacy appointments – were highlighted by others as hampering their ability to maintain a job if, indeed, they managed to secure employment in the first instance. Craig, who previously held what he described as 'cash-in-hand' jobs, told that he struggled to manage clinic attendance during one period when he worked in construction.

"I was working on the building site and it wasn't easy cause I had to go down and give a urine. That was when I was on (the clinic) twice a week – on a Monday and on a Friday I had to go down and during the mornings … I used to tell (boss) that I'd only be two minutes and I'd be coming back ten or fifteen minutes late so it can be hard that way if you're on a job and you're coming back late all the time. People start to get suspicious, 'What's going on like, you only live over there like?'" (Craig, age 35-39)

Other participants similarly spoke about the challenge of potentially having to balance the demands of MMT with those of maintaining a regular job.

"If you're on methadone you need to take time off to get your script, to go to your chemist, you know, and these cause terrible issues." (Catherine, age 40-44)

The daily routine of MMT was one of a number of issues discussed by study participants but, perhaps significantly, was by no means perceived as the greatest barrier to employment. Participants were in fact more likely to express concern about the views of prospective employers should they become aware of their drug use history or participation in MMT. Bernie felt that it would be extremely difficult, but essential, to conceal her 'status' as a drug user in treatment from prospective employers.

"You feel you can't get a job. Like what if your job starts at 9 o'clock and you haven't got your Phy in you all day, d'you know what I mean … And then you're thinking like, 'What if they ask for a medical?' Even though they don't know me, there is stigma

straight away, like who wants to employ someone who is on methadone?" (Bernie, age 40-44)

One participant, who was employed full-time for a considerable period of time, went to great lengths to conceal her MMT from her employer believing that such knowledge would seriously compromise her position and possibly lead to the termination of her employment[9]. This account illustrates the pressures associated with managing and concealing a biographical past that could potentially be 'judged' and, ultimately, punished.

"This is my, it's like how the icing now on the cake would be, do you know what I mean? I can't believe I'm in such a good job and, again, it's just, you put on your mask and you go out the door (after work). And it's like you present to people and they don't know any different, so therefore they can't judge me, you know?"

Fears such as those articulated by this participant had in fact materialised for a small number. Catherine is one of two respondents who reported losing a job following information received by their employers about their attendance at a methadone clinic.

"I didn't want to tell them (employer) about it (MMT), I didn't want to jinx it. I was working away there for months … I was so happy in that job. I absolutely loved it … I was called into the office and sat down and it was eh, 'Well Catherine, it's been brought to our attention that, em, you are in a methadone clinic and we are quite concerned about the parents finding out about this so, I'm very, very sorry but we'll have to terminate you'." (Catherine, age 40-44)

Caring responsibilities, beyond those associated with their children, were noted by other participants as a barrier to seeking employment. Both Seán and Lorraine were caring for a parent who had significant health problems requiring constant or daily care.

"My mother's very ill at the moment, you know … So that role will end soon enough and then I'll go onto something else." (Seán, age 50-54)

"I sort of always have worked here and there. Well over the years now like, I haven't spent my whole adult life on the dole because I actually like to work. A lot of my time at the moment, like I said, is tied up with Dad, but I'm so physically burnt out that I don't know if I could hold down a job now." (Lorraine, age 40-44)

Several expressed a desire to have a job, believing that employment would help to bring greater structure and a sense of purpose to their lives.

"I want to be able to go out into the world and further myself like and get work and get, like there is people that can, that are doing it like." (Dillon, age 35-39)

"I'd love to have a job, I'd love to be able to get up in the mornings and have a job and have a wage and whatever and do all the normal things and you know …" (Seán, age 50-54)

9) As a further measure to protect this participant's anonymity, we have not attached a pseudonym or age range to this narrative excerpt.

However, there were other participants who did not see any realistic prospect of finding a job, with some expressing a sense of resignation to unemployment. At the time of interview, a large number stated that they were not currently seeking employment.

> *"I don't know? It's been so long since I've done it (looked for employment) that I don't know what to expect really, you know what I mean … Yeah, I haven't even thought about getting a proper job for quite a while to be honest."* (Eric, age 35-39)

Those who were enrolled in CE schemes (five in total) at the time of interview tended to be more optimistic about their future employment prospects. These accounts suggest that participation in employment schemes led to positive engagement with others, helped to counter boredom, enabled planning for the future and also engendered a sense of personal purpose and achievement.

> *"You come in whatever days and also you can move up in stages and then, at the end of it all, by the end of it all they hope to have you back in society working and drug free altogether like, you know. So that's what I'm aiming for … so it's good."* (Dillon, age 35-39)

Richie, who had started a CE Scheme approximately six months prior to interview, talked of feeling "more deserving" of social welfare payments and having a greater sense of independence.

> *" … I hated going up and collecting my dole but, since I've started here, it makes me feel like I've earned my money because I'm coming here every day and it makes me feel like a bit more worthy of getting my dole … because I've come here every day and it's not work, it's a course like, but it just makes me feel better about collecting it and I feel like more independent and things like that."* (Richie, age 40-44)

Overall, participants in this study confronted multiple barriers to labour market participation owing to their disrupted schooling, low levels of educational attainment and the lack of a recent employment history. Most who had worked in the past had been employed in low-paid, casual work, often in the construction or service sectors and, consequently, did not have a demonstrable employment history. Other significant perceived barriers to employment included employer perspectives on the drug user or 'addict' and a belief that prospective employers would not consider hiring a person with a history of drug use.

Housing

As documented in Chapter 3, the housing situations of study participants at the time of interview varied. While almost half (n=12) were independently housed – living in local authority (n=7) or approved body housing (n=2), in the private rented sector (n=2) or a privately owned home (n=1) – seven currently lived in transitional homeless accommodation. A further five participants, all male ranging in age from their late-30s to early-50s, lived in the home of a family member. Some participants who lived with a family member(s) felt that their

housing was secure but others were vulnerable to the loss of housing. For example, Alvin, who had a history of homelessness, currently lived with two family members and slept on a sofa in the living area of the residence. Explaining that "I never really had a stable place to live, I've been on and off homeless since I was about 16", he considered his living situation to be very unstable.

[So how do you feel about where you are living?]
"It could be better. It's not a good place to live. They've (family members) let the house fall into disrepair big time. It gets you down waking up there every morning looking around and living in that environment. It reminds you of being back on the streets and all the rest, you know." (Alvin, age 40-44)

Alvin had approached his local authority in an attempt to find alternative and more secure housing but was informed that his application would not be considered until he was "clean".

"I've been in touch with the local authority and they did offer me a place about two years ago but I went for the interview and it didn't go well. They put it on hold, literally, 'Until you get your act together, basically get clean and get stabilised' and come back and see them then … I have to get clean and, like I said, the council won't entertain me until I get clean." (Alvin, age 40-44)

Another participant, who had experienced homelessness in the past and currently lived in the family home, worried about the sustainability of this housing: "If anything happens with my father now I'm homeless like, you know" (Cormac, age 35-39). The experience of living in situations of 'hidden' homelessness, either currently or in the past, was reported by a considerable number. At the time of interview, Dillon was moving between the homes of relatives and, at times, stayed in the home of his partner's family. Following his release from prison a number of months previously, he had initially stayed in homeless hostels.

"When I first got out of prison I was homeless, there was nothing in place for me … And they had me in a hostel in town there and it's just them hostels in town. Like they're just, you have to be sleeping with one eye open, behind the curtains and all, it's just not, so I'd rather sleep rough." (Dillon, age 35-39)

Therefore, although not currently accessing homelessness services, a number of participants were precariously housed and felt uncertain about their housing futures. Those who were currently living in transitional homeless accommodation frequently expressed anxiety about their situations. Six of the seven participants who were homeless were male, almost all of them in their 40s.

"At the moment things are not very good. Homeless, still on drugs, struggling with that and … you could say the best present that could happen to me is to sort out the accommodation, my addictions, that would be my dream. But I know it's not going to happen overnight, I know it's going to take time." (Danny, age 40-44)

The housing situations of study participants can be characterised as a mix of stability and instability. Some reported housing security and had been living in local authority or

private rented housing for a significant period of time. A considerable number of others were vulnerably housed and at risk of homelessness while seven were currently accessing homelessness services. There are some noteworthy gender differences in the housing situations of study participants, with women more likely to live in local authority or approved body housing and men more likely to live in the home of a family member or to be currently accessing homeless accommodation.

Social Ties and Relationships

Social ties and the presence of supportive others in people's lives – including family members, peers and community members – are considered to be important to the reintegration of people who have substance use dependency problems (Brown et al., 2004). Furthermore, effective drug treatment may be significantly influenced by the quality of an individual's interpersonal relationships (Broome et al., 2002). This section presents participants' accounts of their family and peer relationships. It also examines accounts that were strongly suggestive of self-isolating practices or responses, sometimes used by study participants as a self-protective strategy but also closely connected to feelings of exclusion and marginality.

Family Relationships

Accounts of the nature and quality of family relationship varied. Ten participants (including seven males and three females) stated that they had family connections that provided some level of support; a further 10 reported strained family relationships while five participants had no contact with family members. Six of the seven participants who currently lived in transitional homeless accommodation reported that they had either a strained relationship with family and limited family support (n=4) or no family contact (n=2).

When family relationships were present, participants reported meeting and sharing 'news' and everyday experiences. Chris lived in the family home and described family as "very important". His sister had always supported him and he also had a good relationship with his brothers.

> *"Yeah, they (family) do support me, yeah. My sister is very supportive. She always did support me in the past. I mean everyone has their own life but she always took time out to try and help me if I got into trouble or anything like that … But, yeah, I'm happy with the way life is with my family, you know."* (Chris, age 35-39).

Also resident in the family home, Eric was grateful that his parents had not asked him to leave many years previously. He explained that he was trying to make amends for the trauma suffered by his parents because of his drug use, recognising that others with a history of drug dependence could not count on the support of family members.

> *"It's harder for other people, I have my family around me, some people don't have that so it's harder for them. There's no one to like give them a boost or whatever, you know what I mean."* (Eric, age 35-39)

Ronnie, who said that his relationship with his siblings was "healthy now at the moment since I've been clean", also openly discussed the impact of his drug use on family life.

> *"So the whole family had to turn their back on me and there was a lot of discord that I brought to that family. You know, when you're an addict, especially when you're a heroin addict, you don't realise, you think that you're only hurting yourself, but you don't realise the whole family behind you and the disruption you cause. The heartache you cause people who are worried about you and this, that and the other."* (Ronnie, age 45-49)

Over time, some participants had succeeded in resolving past tensions and their family relationships had improved, sometimes quite dramatically. A number of others reported a more gradual process of renewing family relationships.

> [And do you feel like, at the moment, you have support from family?]
> *"I suppose you can never have enough support but, like, it's getting better, yeah, it's improving for me like."* (Dillon, age 35-39)

> *"I'm getting, in the last couple of months now I (pause) see my mother and father are still living down in (provincial town), you know? But I'm, I'm starting to get back to like, back talking to them and all, you know? And like I get on well with them.*
> [And were things difficult for a time with them?]
> *Yeah, they were, they were like on account of like that I was fucking using heroin, you know."* (Conor, age 35-39)

However, a large number described their family relationships as fragile, strained or even fraught. These participants sometimes had contact with one family member (a parent or sibling) but not with others. Lorraine explained.

> *"I'm very grateful to my family that they still consider me or allow me to be a member of or part of the family, you know what I mean? Because I put them all through hell I suppose, you know. They had to watch me turning from a normal sort of sister into this. There was obviously a lot of stealing going on over the years, you know, 20 quid here, 50 pound there and stuff and I'm ashamed of my life of that. Like we still meet up at … and it's civil and, you know, it's fine, but there's no, apart from (sister) now, I'm not really close with the rest of them."* (Lorraine, age 40-44)

Like Lorraine, many others talked about the feelings of shame they harboured over the family ruptures associated with their drug use and to related behaviours such as stealing and lying which very often resulted in their estrangement from family for many years. Ongoing tensions meant that, while some had re-established contact with a family member(s), these relationships were sometimes superficial and lacked meaning. Christine, who said that there had been "no acceptance for who I was or what I was" from her family, maintained contact with her sisters but they met only occasionally and their interactions tended not to progress beyond the exchange of pleasantries.

> *"I've three sisters, but I wouldn't have any relationship. I mean I do talk to them, I say, 'Hello, how are you? How's things?' I wouldn't visit them, they wouldn't visit me. But when I see them I'm polite to them and they are to me and they say 'How are you?', How's the kids? Great', that's it."* (Christine, age 50-54)

Catherine, another participant who reported strained family connections, explained that she does not disclose the truth about her methadone consumption to family members because of a fear of being judged or rejected.

> *"I tried – my family – my Mam now she still asks me the same question every time I see her, 'Are you still taking that methadone? Are you not off that stuff yet?'. As far as she can tell I've been on it forever. So I don't tell them how much I'm on … If they ask I won't, I certainly won't tell them I'm on 85 mls because they've known me to be down to 25, you know?"* (Catherine, age 40-44)

Those participants who had limited or no contact with family members often expressed a mix of hurt and anger about how they were perceived, despite their efforts to make changes in their lives. Leanne's parents were deceased and she had very limited contact with her siblings.

> [Do you have contact with your siblings?]
> *"No, not really. No because you can't bring the person with you. There's just … because of shit that I done when I was much, much younger, they think I'm still like that. I remember going to (a relative's) wedding a couple of years ago and them coming over and thanking me at the end of the night for behaving myself and looking well. I felt disgraceful, I felt disgusted."* (Leanne, age 40-44)

Only a minority of participants described constant supportive relationships with key family members who were aware of their drug use history and with whom they felt able to share or disclose the details of their current drug treatment situations. Family members were not available to a large number or in a position to provide social, emotional or financial support. Difficult relationships with family members were a significant source of stress, compounded for some by a belief that they were ultimately to blame for these family ruptures.

Peer Relationships

Relatively few participants reported that they had 'good' friends with whom they interacted or socialised on a regular basis, with just three describing an active and varied social life. Rachel had completed several courses where she met new people and, more recently, had travelled abroad on a number of occasions. She was connected to a peer network and had friends who were available for social outings.

> *"I go out with friends, like we just go out really for dinner or tea or a walk on the pier or something like that. I don't really go out socialising, as in partying, I'm not like that but … like, it was my birthday there last week and a few of the girls came along, eight or nine of us and we all socialise and have dinner and a great laugh."* (Rachel, age 40-44).

Seán, who described a "pretty simple" daily routine, also discussed his involvement in a number of social activities.

> *"I just live a pretty simple life, I walk the dog, I do a bit of fishing … I'm part of a fishing club where we travel up and down the country. You know, completely different*

lifestyle to the chaos that I came from, absolutely completely. I'm quite contented and happy, reasonably, you know." (Seán, age 50-54)

The vast majority, however, described limited engagement with social activities or peers, with many reporting that their social circles were extremely limited or non-existent. These participants had few, if any, dependable or trusted people in their lives.

"No, I don't have friends. The only social thing I do is go to the gym twice a week. I don't go out at the weekends, I don't go out drinking, I don't meet people for dinner. I mean, if someone says to me, 'Do you want to meet for dinner?', I'll meet for dinner, but I don't have (pause) … I couldn't say to you, 'Oh Mary's my friend', because I don't have a Mary, you know." (Christine, age 50-54)

"I mean, trust-wise I'm not one for trusting people much myself, I've got a few issues around that … Friends-wise I would have one person I would consider a real friend. The rest are sort of people you met through drugs and stuff so I wouldn't consider them close friends." (Alvin, age 40-44)

Past peer relationships were invariably depicted by participants as not equating with 'real' friendships, with very many describing their former drug-using friends as "associates" or "acquaintances".

"You see most, as I said, most of the people I'd link in with I'd only call associates because I'd only know them through drug use." (Dillon, age 35-39)

"I actually hadn't really no friends, I had acquaintances." (Seán, age 50-54)

Simultaneously, many talked about running into 'old' friends, either in the street or when attending the clinic. Irrespective of participants' level of contact or engagement with former drug-using peers, all were clear that they needed to cut ties with these networks and with the social 'scenes' and connections that had previously occupied a prominent place in their lives.

"Yeah, I just don't do anything. I kind of keep away from the old associates like, you know, because I don't want to be getting brought back into that scene as such, you know. I just kind of stick to myself type of thing, just staying away from people that I know are using …" (Dillon, age 35-39)

"I don't hang around that area anymore because bumping into old faces leads to bad things, you know." (Chris, age 35-39)

A number of these participants also told that they had experienced rejection by friends who learned of their heroin use many years previously. This meant that revisiting relationships with past friends beyond those associated with their network of drug-using peers was not an option for most.

"Friends that, like they heard I was doing heroin and didn't want to talk to me anymore, stuff like that, you know. But as far as I'm concerned, go on, go away, call

me what you want. I am who I am." (Chris, age 35-39)

"I still have friends from when I was growing up before I started taking drugs or when I just started smoking hash. But like when I was in addiction, they kind of stepped back from me to protect their family and themselves." (Richie, age 40-44)

Particularly in more recent years, many had experienced the loss of friendships with very many recalling the death of close friends, which were almost always said to be drug-related. Participants often discussed feelings of sadness associated with this loss and several also articulated an awareness and fear of the association between dependent drug use and early and accelerated experiences of loss and death.

"So many people are dropping dead in the last eight years. I've buried more friends than (pause) … I can't even count them and it's terrifying. All the old school addicts are all gone." (Catherine, age 40-44)

"I've seen so many of my friends dying with their livers and hep C." (Cormac, age 35-39)

"Most of my friends have passed away now … people start dying after 45, that is a hard fact. Not many live, who are on methadone all their lives, after they hit 50." (Yvonne, age 40-44)

For a majority of participants, friendships and the notion of having friends presented significant challenges and, to some extent, tested their ability to cope with opposing and sometimes contradictory personal narratives and experiences. Some had experienced rejection as teenagers or young adults by their more conforming or law-abiding friends who opted to distance themselves from them for various reasons. Simultaneously, practically all participants felt a need to detach and dissociate from individuals who belonged to their former circle of drug-using peers. Particularly in more recent years, most had experienced bereavement associated with the death of friends, leading to sadness and feelings of anxiety and stress. Thus, friendship was a complicated 'space' for many, its meaning closely connected to prior drug use contexts, connections and interactions as well as to the loss of one or more of these friends. Forming new relationships and friendships was often perceived as daunting, leading many to withdraw from social relationships.

Self-Isolation

A large number of the study's respondents avoided social contact, often describing very little interaction with others on a daily or weekly basis. This self-isolating behaviour appeared to be an 'abstention' strategy for some, who feared that mixing with others with whom they used drugs in the past could result in a return to the social circles that were part and parcel of their (problematic) drug use histories. Dillon, who described himself as "kind of isolated", discussed not "getting out" and "finding new things".

"I'm not really doing anything active or I'm not getting out, I'm not changing, I'm not finding new things to do. I'm still kind of isolated away, like I'm not finding hobbies or anything, you know … Yeah, I just don't do anything." (Dillon, age 35-39)

Alvin similarly reported that he spent a lot of time "hiding away", explaining that he found it "pretty hard to reintegrate into normal society". He had few social connections that he felt were positive or productive and, for that reason, tended to self-isolate.

> *"I would go fishing during the summer, I do a bit of fishing … Other than that I sort of isolate myself a bit, I'm not one for hanging around on the streets. The way I look at it I've done enough of that over the years, you know. So other than that and visiting the brother at the weekends I wouldn't really be out and about much."* (Alvin, age 40-44)

Feelings of guilt and shame related to past drug use and associated behaviours appeared to negatively impact some participants' ability to have or form new relationships because they feared judgement or rejection by others. These participants expressed ways in which their life and drug use histories hampered their abilities to foster and maintain relationships.

> *"And, you know, I've to live with the guilt of things I've done. I've to live with (pause), I've hurt people, I've hurt my family, I've hurt myself, you know? I let my mother down and every negative aspect that comes with drug addiction, I've gone through, you know?"* (Cormac, age 35-39)

Isolation overlapped with loneliness in many accounts, particularly among those who lived alone or in homeless accommodation.

> *"Like I've met a girl now and, you know, I'm trying … But I've been going home and the loneliness of it all."* (Cormac, age 35-39)

> *"I'm probably quite lonely. It doesn't get me down too much but it's a fact. I can take it because I've been an outsider all my life anyway but I would say other people being this lonely would probably (pause) … it would become a problem for them."* (Kevin, age 55+)

Accounts of seclusion and loneliness were also articulated by participants who were securely or independently housed. Yvonne, who had recently moved to local authority housing, worried about whether her own isolation negatively impacted her children's ability to socialise with their peers.

> *"You see, because I don't mix with people I find they (children) don't mix with people. Nobody ever calls to my house, no one ever knocks on my door, I never get a phone call saying, 'Do you wanna come here or do you wanna go there?'. So they (children) just see me just on my own constantly … So I find they don't mix with people either, you know. I'd even say to (son), 'Tell your friends to call up' and 'No, no, no, it's grand, it's grand, it's grand'. So (pause) … but they kind of need a bit of help socialising."* (Yvonne, age 40-44)

For a number, growing older as a long-term MMT client amplified feelings of marginality, making social interaction more difficult. In Catherine's case, these challenges were compounded by poor mental health.

> *"I find the older I get the more different I feel and the harder (pause) … I'm finding it*

really hard to mix with people who don't use and I was never like that before. And now, it's really starting to get to me now. I don't know if that's because I'm going through a really bad patch of depression at the moment." (Catherine, age 40-44)

A number of female participants talked about the absence of an intimate relationship in their lives. The women quoted below had been involved in violent relationships many years previously and had not subsequently formed new romantic ties. They now had older or adult children, which meant that their caring responsibilities were no longer as time-consuming or demanding. Both talked openly about a desire for intimacy, closeness and companionship in their lives.

"I've sort of been on my own for so long now, you sort of get used to it and it sort of suited me in the beginning … when I got away from him (former partner) I sort of didn't want anyone else. I used to get a lot of offers whereas now (laughingly), I'm not going to get any. I'd say I'm going to be left on the shelf. But, yeah, that sort of loneliness is physically painful, as well emotionally, but I just can't see that ever changing." (Lorraine, age 40-44)

"I don't have friends and I've never had a partner since the day I split with my kid's Dad and I think that just kept me safe. I didn't want another man coming in and maybe hitting me in front of the kids or something like that or demanding the kids or … I just didn't bother. And now I'm (older) and I'm kind of going, 'God, I wouldn't mind, I wouldn't mind someone with me to go away with.'" (Christine, age 50-54)

Another female participant felt that she would not be accepted as a romantic partner because of her status as a methadone patient.

"To have to actually tell them (romantic interest) one day that you're on methadone. They'd run a mile – they wouldn't want to bring you home to mammy and daddy. Do you know what I mean, so you kinda, I'm cutting meself off from that side of society because of this fuckin' thing (methadone)." (Catherine, age 40-44)

For a large number, operating in the conventional world of family, peers, neighbourhood and social life presented significant challenges. Already marginalised by their lengthy drug use histories – and the losses associated with a drug user 'identity' – a majority were relatively socially isolated. Participants demonstrated an awareness of the obstacles created by social isolation but, equally, seclusion and a fear of interacting with others was a significant dimension of life experience that many found difficult to confront and address.

Managing Stigma: "I'm always hiding and ducking and diving"

"Well, you know, if people know you're on methadone, they do treat you completely different. You know, they do, they don't take you seriously like. I find when people don't know anything about that, they actually treat me like just a normal person … If someone seen me coming in here (the clinic), they might tell my (adult child), they might tell one of my family or something like that. So I'm always hiding and ducking and diving and waiting on all the cars to pass, you know? I've often missed the clinic from hiding down the road." (Christine, age 50-54)

Despite its efficacy and widespread use, MMT continues to be largely stigmatised and stigmatising, with patients often experiencing stigma and discrimination associated with their treatment (Conner & Rosen, 2008; Lloyd, 2013; Woo et al., 2017). Indeed, the stigma associated with MMT is said to be particularly strong (Earnshaw et al., 2013; Smith, 2010; Tempalski et al., 2007). Institutional stigma – which denotes those negative attitudes and beliefs towards methadone reflected in an organisation's policies, practices or cultures – has been documented in the literature (Anstice et al., 2009; Harris & McElrath, 2012). Other sources of stigma experienced by MMT clients include the family, friends and the neighbourhood (Earnshaw et al., 2013; Conner & Rosen, 2008). Finally, self-stigma, which refers to "negative thoughts and feelings (e.g. shame, negative self-evaluative thoughts, fear) that emerge from identification with a stigmatized group" (Luoma et al., 2007: 1332) is an important, albeit lesser explored, dimension of stigma. Self-stigma occurs when people internalise public attitudes and can lead individuals to suffer negative consequences, including decreases in self-esteem and self-efficacy (Corrigan & Rao, 2012).

Accounts of stigmatising experiences were pervasive, with participants frequently confronting stigma on multiple levels as part of everyday life. This section examines the ways in which stigma was experienced by study participants, with particular attention directed to the stigma of MMT.

As documented in the previous chapter, participants frequently described ways in which they felt stereotyped as methadone treatment clients by medical and other professionals in the clinics they attended. For example, many recounted feeling stereotyped as not trustworthy and incapable of decision-making in relation to their treatment. Negative experiences of interacting with clinic and pharmacy staff were highlighted, often with reference to what participants felt were responses based on stereotypical assumptions about their lives. Institutionalised stigma of this nature extended beyond drug treatment settings and included several other contexts where participants reported experiences of being 'singled out', treated differently, excluded or demeaned because they were clients of MMT. Maternity hospitals were specifically mentioned by four of the study's women as places where they felt exposed, humiliated and publicly ostracised.

> *"Well my hospital chart, straight across the front, it said 'methadone', where everybody else in the hospital could see. All the other normal people and I'd be sitting in the place with methadone right across my file. And then every time I went in I was treated like I was just a dirty, dirty, drug addict who was just, 'I don't even wanna touch her. Just get her done, get her out, she can't be clean'. They would not believe me that I was clean."* (Yvonne, age 40-44)

Rachel, who reflected on her hospital visits during pregnancy many years earlier, told that it was only in hindsight that she understood the impact of how she was treated.

> *"So it was only in hindsight that, like after the fact, and all the years later that I look back and go, 'Jesus, such a terrible way to treat someone', you know what I mean like. But when you're in it, you're on the floor like with it, you don't really see that it's so, so damaging to be treated so badly."* (Rachel, age 40-44)

Several others recounted negative experiences of interacting with state agencies, including housing, homelessness and social work services. These accounts tended to emphasise a constant preoccupation on the part of the individuals with whom they interacted with their drug user or 'addict' status: "When I went to the council, all they were focusing on was the heroin, the drug use, you know … they just looked down on you straight away and they just think you're what they would see on the streets" (Alvin, age 40-44). In situations such as these, participants did not feel that they could 'speak back' or challenge the assumptions that were made about their lives. These experiences were reported to have traumatising effects, one of the most significant being a belief that it was impossible to escape, much less resist, these structurally reinforced stereotypes: "I got an identity to that now. Maybe, yeah, it's negative thinking but it is the reality of what's after happening in my life" (Cormac, age 35-39).

Stigma experiences were not limited to institutional contexts. Indeed, several respondents talked more frequently about everyday stigmatising encounters in their neighbourhoods and also in their interactions with family members. Yvonne told of the response of parents in her neighbourhood who became aware that she was a methadone client and would no longer engage with her in the school yard. She expressed strong concern that her children would be treated differently as a consequence.

> *"Well yeah, some of the parents saw me going into the methadone clinic and they haven't spoken to me since … And these would be parents of kids that would be in the same class as me kids. But they seen me going into the clinic and then they're like, 'Oh, she's a druggie'. And then you're looked at totally differently. And some parents at the school they still don't talk to me because they seen me going into the clinic two years ago … Because I'm going in the clinic I'm obviously a junkie so avoid her. But then you feel that, 'Oh, me kids are going to feel differently' because they're probably saying to their kids, 'Don't hang around with that kid'. And it ends up passing down and going to the kids because I was seen going into the clinic."* (Yvonne, age 40-44)

Accounts of stigmatising experiences in the neighbourhood were sometimes strongly connected to clinic and pharmacy attendance. The public nature of these settings meant that participants were observed by others in the community, making it difficult to conceal their status as methadone maintenance clients. Some felt publicly exposed and shamed by this experience.

> *"Sometimes you feel that people know you're on it (methadone), you know, and they look at you, they look down on you. I used to get that a lot, especially being I have to drink the methadone in the chemist even though you go in behind the thing (partition). But I do find if you're drinking it there that people will be looking at you."* (Ciara, age 40-44)

> *"Like when I'm going into the clinic and you have to turn around and show your face and people see me going in and (they're thinking), 'I thought you stopped that (methadone) years ago."* (Deirdre, age 35-39)

Like Deirdre, others made reference to their age and the longevity of their treatment, both of which constituted additional layers of stigma and shame.

"That one word straightaway gives them your whole history: methadone. It lets them know that there is a threat and then, if you're in your 40s, and then they're thinking, 'Oh god, she's in her 40s and she's still taking methadone, she probably still takes heroin', you know what I mean. Because that word methadone, it's not associated with any other illness." (Catherine, age 40-44)

Beyond public settings, participants also recounted stigmatising experiences arising from their interactions – or, more commonly, their lack of interaction – with family members. As documented earlier in this chapter, the quality of participants' family relationships varied, although many reported ongoing family tensions as well as distant or fraught relationships with one or more family member. Referring to the assumptions made by some family members, a number felt that they had lost the trust of family. Bernie was not invited to family gatherings.

"I wouldn't get invited to family things like. I think they thought I was a robber or something because I was on drugs. Do you know that I never robbed anybody while I was on drugs." (Bernie, age 40-44)

Exclusion from family events was reported by others and was often depicted as particularly hurtful. Others responded with anger: "I didn't get invited to (family) christening. I don't get invited to family do's (gatherings) so to hell with them" (Leanne, age 40-44).

Participants in this study were managing the impact of stigma on a constant basis, with many expressing hurt, upset and distress about how they were perceived by others. However, for most, the impact of stigma was a deeply private experience. Referring to the prejudice that surrounds addiction, Alvin explained his attempts to "fight back".

"There's a lot of prejudice to drug addiction, you know. They're all, 'Oh it's their own fault'. But, you know, when you try and battle back, the resistance, the resistances are phenomenal … you've to fight and claw for your life." (Alvin, age 35-39)

Later in the interview, Alivn elaborated on the effects of stigma, commenting that developing a "thick skin" was perhaps one inevitable consequence. For Alvin, 'accepting' the responses of others was an option but not one that would negate the lived experience of stigma.

"It's just the stigma sometimes, you know, that I have to fight all the time, you know? Like growing that thick skin, because people aren't just going to accept you for it. Ah yeah, people say, 'Well done, you're doing great and fair play', and all, but there's other people, 'Ah you're a junkie scumbag'. And all this goes on … People say hello to you in the street and shake your hand, 'Fucking see him? Sweet Jesus, he's on methadone'. But that's part of life and, you know, if I was to say, 'Yeah, I do accept it', it doesn't mean it doesn't hurt anymore." (Alvin, age 35-39).

Alvin's account illustrates the multiple layers of stigma that were "part of life" for a large number. Irrespective of gender, stigma was internalised by participants: "That's what you do as a drug addict – you let people down, you're unreliable, you're of fucking no use to nobody" (Cormac, age 35-39). However, narratives of self-stigma were particularly apparent

in the accounts of female participants and also had some distinctive characteristics. For example, a number referred or alluded to change in their bodies and physical appearance and several talked about dental problems and tooth loss, which they found distressing. Lorraine felt that she was "judged" because of her appearance.

> *"My appearance has changed a lot in the last sort of 20 years. I didn't look like this, I used to be pretty. I suppose I've lost all my teeth as well. Well, I look like a junkie now and people judge, I certainly get judged a lot on my appearance."* (Lorraine, age 40-44)

Self-critical remarks featured strongly in the accounts of some of the study's women, particularly when they reflected on their situations, past and present, and their 'journeys' through drug treatment. When asked what methadone meant in her life, Christine responded by suggesting that the substance mirrored the "worst" part of her.

> *"It's always, it's (methadone) like holding up a mirror and saying, 'This is the worst of you', you know. I can't function properly. I want to do so much in my life but it holds me, it holds me back for me. It's a bit like a jailer really, isn't it?"* (Christine, age 50-54)

Speaking about the negative consequences of a relapse during her 30s, Catherine harboured strong feelings of regret, recalling that she could have made better choices during what was a particularly challenging period of her life. She questioned whether she could, in the future, embrace the "good stuff", describing herself as a "junkie in disguise".

> *"You know, I've had so many opportunities like come my way and I'm not able. I don't feel (pause) … I feel like I'm a fake, that I'm a fraud … that if I try to go and do all this good stuff that I'm a junkie in disguise."* (Catherine, age 40-44)

Stigma, which is linked to institutional, public, and private shame (Vigilant, 2004), was very present in participants' accounts of everyday life. Managing the stigma of drug use and drug treatment – often depicted as a deeply private experience – presented numerous challenges connected to feelings of rejection, hurt and anger. Irrespective of participants' responses, stigma acted as a strong barrier to social participation and also thwarted the self-improvement aspirations and efforts of a large number.

Conclusion

As stated at the outset of this chapter, social reintegration – which encompasses "activities that aim to develop human, social, economic and institutional capital" (EMCDDA, 2012: 14) – is considered to be a foundation for drug treatment and recovery from drug dependence. The findings presented in this chapter – which have focused on participants' everyday lives, experiences and relationships – strongly suggest that the vast majority were not socially integrated and that this lack of integration placed them at high risk of further social exclusion. Most were unemployed, several were homeless or precariously housed and a

large number did not have access to social support from family members or friends. In other words, participants in this study had multiple unmet needs in relation to housing, education, training and employment.

Prominent in the accounts was the extent to which participants engaged in self-isolating practices. Other studies have similarly found older drug users to self-isolate because of embarrassment, shame and/or a fear of rejection by family members and others in the community (Ayers et al., 2012; Smith & Rosen, 2009). A large number described daily lives characterised by seclusion and loneliness, often related to a lack or absence of social relationships but also strongly associated with stigma, which most experienced on multiple levels. Drug addiction stigma continues to impact the lives of individuals with a history of problematic drug use, even after they access treatment (Earnshaw et al., 2013) and there can be a particular stigma attached to MMT (Lloyd, 2013; Woo et al., 2017). The findings presented in this chapter indicate that growing older as a long-term methadone patient exacerbated feelings of stigma and stigma-related stress. A powerful, yet frequently unspoken and silenced experience, addiction and drug treatment stigma undermined participants' ability to participate and experience a sense of belonging in their communities. Furthermore, the range of institutions with which they interacted – including those related to drug treatment, housing and health – frequently served to legitimate discourses that reinforce and uphold the stigma of drug use, addiction and methadone treatment.