An exploration of women and crack cocaine use in Ballymun: trajectories, experiences, and interventions

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Citation:
O'Reilly, Laura, Mac Cionnaith, Criostoir, Lawless, Marie. (2024) *An Exploration of Women and Crack Cocaine Use in Ballymun: Trajectories, Experiences, and Interventions*. Dublin: Ballymun Local Drugs and Alcohol Task Force in partnership with Urrús/Ballymun Youth Action Project.

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Authors Note

The experiences described by the 13 women who participated in this study are vivid, moving and unrestricted in their delivery. Requiring responses to be equally captivating, strong and embracing. We would like to thank each of the thirteen women, and hope that we have afforded understanding, empathy and sensitivity to this research. Our relationship with this research has been difficult. While it was anticipated given the area of focus, we were unprepared for the extent of the emotional connection which ensued.

We would also like to thank the following for their contribution and support; Dr. Sarah Morton and Gabrielle Gilligan for reviewing the report, the Ethics Committee of Ballymun Youth Action Project, Roisin Byrne and the management and colleagues in Ballymun Local Drugs and Alcohol Task Force, Ballymun Youth Action Project, Ballymun Communications and Urrús. To Professor Catherine Comiskey for her continuous support for community research, report foreword and launching the report.

Our knowledge on women and substance use in Ireland is ever increasing, we are fortunate to have leading research on the subject undertaken by Dr Morton, Professor Ivers, and Professor Comiskey. This local report shares similarities and signals our responsibilities as a country and a community to strengthen our collective action.

Laura, Criostoir and Marie

Foreword

Thank you for the opportunity to review and provide a foreword for this report. It is always a privilege to be involved with the wonderful community work that has been conducted in Ballymun over the years. From my perspective, the contribution of the community voice to evidence-based practice within Irish substance use policy, is the envy of Europe. It is locally based community reports such as this one that have fed into wider European and global policies and commitments. This can be seen in the contributions from Irish community services to the series of four volumes on women, children and parents who use substances which have recently been produced by the Pompidou Group. (https://www.coe.int/en/web/pompidou/children)

What has struck me most about this new report from O'Reilly, Mac Cionnaith and Lawless is not just the sensitivity with which the authors have approached this deeply challenging and traumatic topic, but the practical and informative findings that they have drawn from their truly amazing participants. The women who participated have humbled me with their integrity, their strength and their resilience. A sincere thank you to them for sharing their journeys with us their readers.

While the findings of this report are challenging to read, it is, in my opinion the notion of transitions that stands out as the greatest opportunity to make a difference. Transitions and moments of opportunity arise across the child to adult developmental period. From the birth of a child into a home with substance use, to entering school, adulthood, potential motherhood and engagement with health, social and other services. While we cannot deny the role of adverse childhood and adverse community experiences each service can make a difference if we focus on moments of engagement during transition periods.

I fully support the specific areas for consideration expressed in this report. Furthermore, as we enter a period of a new national drug strategy, I urge policy makers to be creative and to address recommendation one of this report and to provide an agreed framework where we can 'mind the gaps.' We can use transition periods as a time of opportunity, not as a time when women pass through unnoticed and hidden but a time to ask, to intervene and to support.

Thank you,

Prof Catherine Comiskey, PhD, FTCD.

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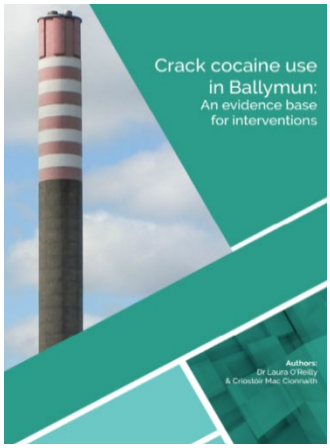
Introduction

'Crack cocaine use in Ballymun: An evidence base for interventions' (O'Reilly & MacCionnaith, 2019) was conducted at a time of significant concern around increased visibility in the use, dealing and impact of crack cocaine in Ballymun. The Ballymun community continues to be an area challenged by poverty, unemployment and social problems including substance use, health and other trauma experiences (Montague 2021). The population figures have remained largely unchanged, however the Ballymun area highlights the continuing nature of disadvantage in the most recent Census. Ballymun displays higher rates of disadvantage, very disadvantaged and extremely disadvantaged than those observed nationally (HSE, 2024). There has been an escalation in substance use and grooming of young people into an active localised drug market, with community members and organisations reporting the continued negative impact of crack cocaine use on individuals, families and the community (O'Reilly & MacCionnaith, 2019).

Crack cocaine in Ballymun remains a persistent feature of the local drug patterns of use as well as within sale and supply networks despite an active response from multiple agencies, in the five years since the 2019 report. Responses have included targeted operations/seizures; greater knowledge on patterns of use; crack cocaine specific training for practitioners and services; enhanced service responses including expanded outreach, crack pipes distribution and harm reduction information and supports; family support for family members affected by crack cocaine use; as well as providing food and hygiene support ensuring basic needs are met. Despite the complex needs which exist in Ballymun, it continues to demonstrate creative and participatory ways of responding to the presenting challenges and consequences. Ballymun has strength in community and collaboration. There are well established addiction services and supports which integrate person and area responses with local youth, family, health and housing resources. The range of local structures, programmes and processes in place optimises the capacity and possibilities of inter-agency work to improve overall outcomes.

The current research aims to build on findings emanating from the previous report and to explore the experiences of women using crack cocaine including their substance use and crack cocaine use trajectories; health and social experiences and intervention and supports needs.



Recommendation 4. Women and crack cocaine

The gendered dimensions to crack cocaine use were examined in this research, highlighting specific concerns around women and crack cocaine use. Given the complexity of these issues two key actions are recommended. Firstly, further local research to explore in greater depth women's use of crack cocaine and associated consequences and implications. Secondly, targeted outreach intervention to women around the core issues of sex work and accommodation supports (O'Reilly & Mac Cionnaith 2019, p53).

Context

Cocaine is the second most used illicit drug in Europe with poly drug use increasingly reported alongside associated increasing health risks and public health challenges (EUDA, 2024). National data shows that 289,000 (7.4%) adults in Ireland reported recent or last year use of any illegal substance with men more likely than women to report illicit substance use (10.2% compared to 4.7%) (Mongan, Millar & Galvin, 2021). Cocaine was identified as the third most used drug, with men more likely than women to report recent use of cocaine (2.8% Vs 0.9%) (Mongan, Millar & Galvin, 2021). Increased availability, purity, and aggressive sales tactics have been identified as key drivers in the rise of cocaine use in Ireland (Mongan, Millar & Galvin, 2021). Figures from the National Drug Treatment Reporting System (NDTRS) showed an increased number of treated cases in Ireland in 2023 (13,104 cases) with women accounting for 31.1% of cases entering drug treatment in 2023 (Lynch, Condron, Lyons & Carew, 2024). Cocaine was the most common drug reported for treatment seeking in 2023 while demand for treatment for crack cocaine use increased by 33.7% between 2022 and 2023 of which 46.2% were female (Lynch, Condron, Lyons & Carew, 2024).

The high availability of cocaine and crack cocaine is having a growing negative impact on public health in Europe and has been found to be related to several psychiatric and psychosocial problems (Perrenoud, 2021; EUDA 2024). The role of social issues and the associated impact on community is an important consideration given that, in some countries, cocaine use appears to be increasing among more marginalised groups (Mongan, et al., 2021; EUDA, 2024). In Ireland, communities with high levels of deprivation have been found to be 'disproportionately' impacted by the negative effects of drug use activities in their local area with those in deprived communities found to be twice as likely to experience drug-related intimidation and to report greater problems with people using or dealing drugs in their local area (Mongan et al., 2021). Research has also highlighted the relationship between area-based disadvantage and the prevalence of drug and alcohol treatment episodes (Collins et al., 2023). Drug policies addressing socioeconomic factors such as poverty, unemployment, educational disadvantage, social exclusion and housing problems are vital given the widely established links between problem drug use and such social factors (Buchanan, 2006; Butler, 1997; Murphy, 1996) and the recognition that drug use disproportionately harms people who experience challenging lives rooted in poverty and inequality (O'Gorman, Driscoll, Moore & Roantree, 2016).

Similarly, gender sensitive policies and responses to substance use have gathered momentum in recent years recognising the need to evaluate the impact of gender sensitive responses and policies (Mutatayi, Morton, Robles, Pálsdóttir, and Pires, 2022). A key objective of Ireland's current National Drug Strategy 'Reducing Harm, Supporting Recovery, 2017-2025' is to increase the range of wraparound community and residential services for women including women who are pregnant and mothers; and to address barriers that women experience in accessing and sustaining treatment opportunities (Department of Health, 2017).

Much of what is known about addiction and recovery is dominated by research with men (Covington, 2002; Monahan, Steinberg, Cauffman, & Mulvey, 2009). Ireland has responded to this gendered knowledge gap through the qualitative examination of the use of substances by women (Morton et al., 2022; 2023; Ivers, Giulini and Paul, 2021; Galligan & Comiskey, 2019). The availability of such studies is important given the gendered differentials underlying the mechanism of addiction (Rhodes, Gottfredson & Hill, 2018); as women now represent an increasing proportion of those with substance use disorders and treatment seeking cases (Lynch

et al., 2024); and as understanding how substance use disorders differ between men and women is critical to optimizing prevention and treatment and to ensuring that treatments initially tested in men are also safe and effective for women (Greenfield et al., 2010).

Significant gender differences ranging from the biological effects of substances use on the body, to the functional impact, course, and treatment of substance use disorders have been recognised (Lejeuz, Bornovalova, Reynolds, Daughters, & Curtin, 2007; Greenfield et al., 2010). This has attracted increased attention from policy makers and practitioners as use of crack cocaine by women is associated with numerous health and social problems for women. Health problems including cardiac and respiratory illness, frequent burns to lips, mouth, and fingers, unplanned pregnancies, violence-induced injuries, depression, acute psychosis, insomnia, involvement of women in sex work in exchange for crack cocaine or for money for crack cocaine and increased risk of HIV and sexually transmitted infections have been documented (Fischer et al., 2015; Bungay et al., 2009; O'Reilly & MacCionnaith, 2019). Crack cocaine use amongst women has also been associated with acquisitive crimes such as burglary and shoplifting (Fischer et al., 2015) along with their housing and accommodation situations negatively impacted including experienced 'cuckooing' and 'hostile takeovers' (Burgess, 2003; Connolly & Donovan, 2014).

Substance trajectories and gender distinctions with respect to substance use trajectories propose a clear connection between childhood trauma such as domestic violence, abuse, parental drug use, poverty and bereavement/loss and later substance use initiation pathways (Morton et al., 2022; 2023; Ivers, Giulini and Paul, 2021). Similarly, Bungay et al. (2010) highlight the importance of the interrelationship between historical trauma, continuing violence, poverty and other structural inequities in attempting to understand and address women's experiences of crack cocaine specifically. Understanding substance use using a trajectory framework allows for the conceptualisation of the patterns of substance use behaviour including onset of use, acceleration of use, development of regular use, cessation of use and relapse (Hser. Longshore & Anglin, 2007). In terms of onset of use, research proposes that individuals who use drugs at early stages are more likely to use drugs more frequently, accelerate their use and to engage in more persistent substance use.

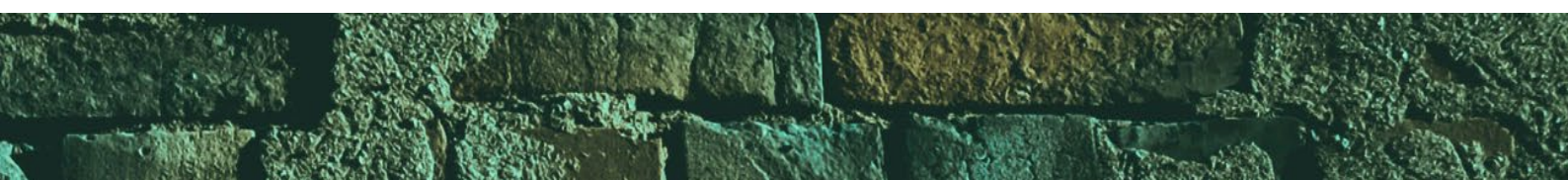
Women are less likely than men to attend drug and alcohol treatment services (Ivers et al., 2021) as they face issues over and above those experienced by men, and for some women, these issues may act as obstacles to seeking, entering, engaging with and remaining in treatment (Arpa, 2017). Transitions, turning points and social capital are important concepts in the life course of drug dependence (Hser, Longshore & Anglin, 2007). Rhodes et al. (2018) identified three core turning points – rock bottom experiences, being sick and tired and shifting identities. Turning points and transitions are important considerations as they provide potential intervention points for women with substance use disorders. Barriers to recovery in women with trauma and substance use disorder include criminalization of substance use, gender-specific stigma toward substance use, and physiological effects of trauma on coping and resilience (Carter-Orbke et al., 2023). Social and personal resources including supportive family relationships and self-esteem can be instrumental in overcoming substance use (Morton et al., 2023).

Stigma is a factor that requires considerable thought and discussion not only in relation to women's substance use trajectories but also in relation to the seeking of and accessing treatment and recovery services (Ettorre, 1992). Women who use substances face considerable stigma which results in the 'silencing' of women, forcing women to attempt to keep their substance use hidden. This stigma is rooted in the social construction of gender based

stereotypes, rendering women who use substances to be viewed as 'inadequate' as women (Ettorre, 1992). Along with stigma, substance use treatment seeking by women has been hindered by an array of issues relating to fear of losing children (Stone, 2015); a lack of available childcare; and, family responsibilities (Jackson and Shannon, 2012). Although pregnancy and motherhood can be strong motivating factors for entering into treatment, the potential harms to the children of mothers who use drugs is frequently expressed with research studies tending to focus on women's shortcomings as women and mothers and the potential problems that might be experienced by their children (Radcliffe, 2011; Couvrette et al., 2016). Hidden harms to children of parents who use alcohol and drugs has been recognised and highlights the need for the allocation of community level resources; and, the need to improve collaboration and interdisciplinary communication between drug and family services (Galligan & Comiskey, 2019; Morton et al., 2023).

Due to the high levels of stigma and trauma experienced by women the need for programmes to address the multiple issues that women face through a trauma informed and gender responsive approach has been recommended (Ivers et al., 2021; Morton et al., 2023); and the establishment of gender specific treatment services addressing women's needs around pregnancy, childcare, domestic violence, sex work, co-occurring mental health issues and homelessness (Morton et al., 2023).

This section has presented a brief overview of existing literature on women's use of substances including crack cocaine. This overview also presents literature on the various impacts and consequences of use as well as relevant treatment seeking and support issues. The next section outlines the research methodology, which is then followed by a presentation of the research findings and a discussion of the implication of these findings.



Methodology

Research Aim & Objectives

This research aims to build on and respond to the previous findings emanating from the previous report (2019) by O'Reilly and Mac Cionnaith 'Crack cocaine use in Ballymun: An Evidence Base for Interventions' by exploring the experiences of women using crack cocaine including their substance use and crack cocaine use trajectories; health and social experiences and intervention and supports needs.

The objectives of the research were as follows;

1. To explore women's trajectories into substance use;
2. To explore women's trajectories into crack cocaine use;
3. To understand women's experiences of using crack cocaine – including patterns and frequency of use;
4. To identify the health implications experienced as associated with use of crack cocaine;
5. To identify the social impacts experienced through use of crack cocaine;
6. To explore women's experiences of treatment and rehabilitation; and
7. To understand women's experiences of accessing locally and nationally available supports/interventions.

Research Design

A qualitative methodology was adopted for the purpose of this study. As Rhodes (2000) has argued, qualitative addiction research seeks both to describe the social meanings that participants attach to drug use and the social processes by which such meanings are created, reinforced, and reproduced. In particular, qualitative research focuses on exploring the details of people's lived experiences and on appreciating why drug-using behaviours occur and how they are understood in different contexts among different social groups (Rhodes, 2000).

Research Participants and Recruitment

A purposive sampling method was employed for the selection of the participants, as this was the most appropriate approach conducive to research aims and objectives (Denscombe, 2015). As one of the researchers was a community outreach volunteer, existing established relationships were already in place with most of the women. Other women were recruited through local treatment and rehabilitation services. However, there were significant recruitment difficulties in relation to women and crack cocaine use which resulted in recruitment taking place over an extended period that wasn't originally envisaged. This was for a number of reasons:

- Some women were actively using crack cocaine and didn't wish to discuss current circumstances.
- Others in recovery didn't wish to recall or reflect on that part of their life.

- Disclosure of personal information around drug use, behaviours or actions taken to obtain crack cocaine.
- Stigma around drug use and women; crack cocaine and/or women, crack cocaine and role as mothers.
- Crack cocaine perceived by some participants as having a grasp on their lives, experiences and impacts.
- Some women had indicated their willingness to participate and were then reluctant to engage prior to interview.

Potential research participants were contacted by phone or in person to discuss the research aim and objectives and what their participation would involve. Where potential participants agreed to take part in the research, they were then provided with a research information sheet and invited to take part in the research. At that point a member of the research team once again discussed further the research aims and objectives and gained signed consent to participate. In some instances, accompaniment to the interview was also offered or provided for participants who wished to avail of it. Participants were also offered access to therapeutic supports if required after the interviews.

Participant Profile

The following table conveys an overview of the thirteen women who participated in the study and their self-reported characteristics and experiences.

Research Participant Profile	13 Women
Age Range	30-47 years
Age Range of First Drug Use	11-18 years
First Use of Drugs before 15 years	11 women
Current Drug Status	All women were using more than one drug or type of drug 7 women were in self-described recovery 6 women were actively using substances
Parenting Status	9 women were mothers
Treatment History	8 women had been to residential treatment 8 women had relapsed upon their discharge from treatment 12 women had been on a methadone treatment

Data Collection

Data collection took place over the latter part of 2022 and 2023. All interviews took place in Urrús Training Centre, Ballymun. Interviews lasted on average between 40-60 minutes. Individual interviews were conducted by one researcher (Dr Laura O'Reilly) given that a therapeutic/service relationship with potential research participants did not exist. All individual interviews were conducted face to face and were audio-taped and written notes were made during the interviews,

which were then externally transcribed. Qualitative data was collected through semi-structured interviews with women who were current and/or former users of crack cocaine (n=13).

Data Analysis

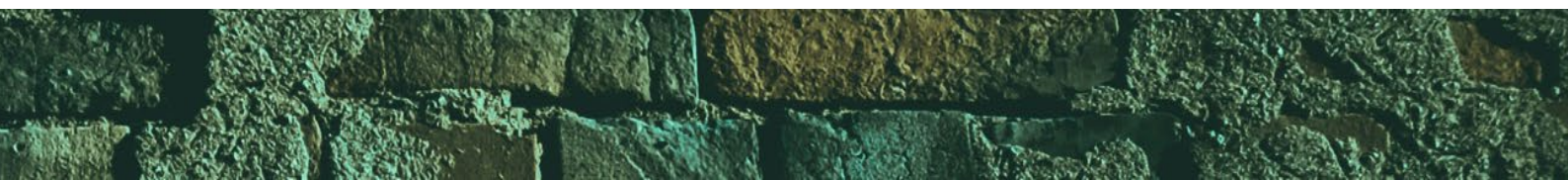
Interviews were audio-taped, transcribed and all data collected was managed using thematic content analysis (Braun & Clarke, 2006). Through the coding process, codes were established and themes identified (Miles and Huberman, 1994).

Ethical Approval

An ethical approval submission was made to the ethics committee of the Ballymun Youth Action Project Board of Directors. The research proposal, ethics application and approval notification were also submitted to the BLDATF as financial support was provided for transcribing, report design and print.

Informed Consent, Anonymity and Confidentiality

Research participants were informed of what they were consenting to both verbally and in writing and were asked to give consent both verbally and in writing by signing a consent form. Potential research participants were provided with a written research information sheet. This information sheet contained information about the purpose of the research, the methods of data collection, estimated length of the interview time and the number of research participants. Research participants were informed that their participation in the research was voluntary and that consent to participate could be withdrawn up to the point where data is anonymised. All participants signed a consent to participate form. All research participants were assured of anonymity. All research participants were assigned a unique identifier, and all transcriptions and quotes were identified in this way. Interview audio recordings were deleted once transcripts had been received and written interview/focus group transcriptions were held on file electronically on a password protected computer. Research participants were assured that all information discussed in the individual interview or focus group would only be used for the purpose of this research and subsequent report and publications. This was outlined in the research information sheet. Researchers informed the research participants of limits of confidentiality, the types of disclosures and to whom such disclosure would be required, also in accordance with the BYAP confidentiality and limits to confidentiality policy and best practice guidelines. An explicit statement about who will have access to the data; information on how the data will be retained; and what measures will be taken to ensure the research participants identity remains anonymous was also provided.



trajectories, experiences & interventions

Findings

Five major themes, and sub themes emerged from the research and are illustrated in the table below. Each of the findings will be discussed in detail in this section.

Key Themes	Sub Themes
1. Childhood & Early Adult Adversities	Parental and familial substance use Disrupted familial relationships Bereavement and loss Substance use initiation and patterns
2. Crack Cocaine Use	Initiation of use Patterns of use Immediate impacts of use
3. Health and Social Implications	Physical and mental health impacts Housing and homelessness Disrupted relationships Crime and incarceration
4. Experiences and Identities	Intimidation Exploitation Stigma
5. Transitions, Treatment & Support	Gaps and challenges Motivators Facilitators

1. Childhood and early adulthood adversities

Childhood and early adulthood adversities were reported as being related to first use of substances and escalation of substance use. The women identified several traumatic and adverse experiences related to parental and familial substance use; bereavement and loss of a loved one; and, disrupted familial relationships, that they believed played a role in their substance use initiation.

Parental substance use

Exposure to parental and familial alcohol use was a common occurrence within the family units of the research participants, with some women identifying their parents as 'drinkers' and 'alcoholics' when they were children:

> *My dad was a chronic alcoholic, and my mother was let's say drink dependent. She would get four cans every single night. Both my mother and father passed away.* [Participant 8]

> *My parents were drinkers, they would've drunk every day, well, every night. They would've gone to the pub every night; they weren't into drugs.* [Participant 5]

In addition to heavy alcohol use, several of the participants were exposed to the use of other substances by parents and extended family members with some family members described as being 'addicted' to other substances, including heroin.

> *Well, I grew up, my mum, she says she's not an alcoholic, but she's never not drank, and my dad was a heroin addict, so I was around it all the time*. [Participant 1]

The visibility of the use of substances by their parents and witnessing substance use by their parents within the family home was furthered as some women used substances with other family members including their parents and siblings:

> *When I lived with my dad, he used [heroin] in front of me. He was meant to come up for my confirmation and he just was a no show, and so I had a feeling something happened to him*. [Participant 8]

> *I'd seen how happy it [drugs] made my dad and I didn't know when to stop, so I just went onto the next thing that I could*. [Participant 5]

In addition to their parents and siblings, problem substance use and substance addiction was reported within their extended family units with a number of women describing an extended family cluster of drug related harms:

> *Bearing in mind my cousins were selling heroin and dealing it in the area. Two of them OD-ed [overdosed] eventually, and died, and my brother was a heroin addict, so it was always around in the background*. [Participant 9]

The visibility of and exposure to substance use by parents and siblings within the immediate and extended family unit also created a sense of normalisation around substance use for the women:

> *In my immediate family, there would be a lot of addicts in it. My brother was already taking class A drugs. I was on the spiral to go in that direction, and I didn't even know it, and then the two of us started using together. It was so normalized in our house*. [Participant 9]

Disrupted familial relationships

The impact of problem alcohol and other substances within participants' immediate and extended family structures was highlighted along with how a parent's use of substances interrelated with other issues like domestic violence. Domestic violence was a common feature of participants' childhoods and was associated with alcohol and other substance use within the family unit. The women were negatively impacted, felt fearful and anxious, and had a sense of emotional disconnect from other family members:

> *I feel that, because me ma and dad were the way they were [taking drugs], I don't really have many actual memories of being a child. I just remember my first ever memory is my dad's killing my ma and I'm holding my brother's hand, and I'm about three and a half. I'm minding him in that situation, so that's the feeling and the memory, but it's really like a picture memory. And then I would be hiding my ma under the bed, and in the wardrobes, so my dad wouldn't see her*. [Participant 9]

Women also faced childhood difficulties due to challenges to their parents' capacity to parent them as children resulting in some women stepping into a mothering and parental role which included being responsible for, caring for and protecting their siblings:

What ended up happening was I really was minding him [dad], and then minding me ma, so I feel like I was the mother in that family for years, and even though I didn't know it then, in hindsight, I'm thinking that's not right, that's unfair. That wasn't really fair on me, but then my da and ma's situation was obviously really volatile, and I've obviously blocked a lot of that out, but I don't have any good memories of it, except when I was with my nanny and grand dad, which I'm blessed for that. [Participant 9]

The felt need to assume adult and parental responsibilities within their family unit as children was found to negatively impact their development as children, creating a burden and feeling preoccupied and worried for and about themselves and other family members. Alcohol and other substance use played a role in relieving some of the worry that was attached to the adult and parental responsibilities that they had as children:

I was always preoccupied with what was going on at home, what I was walking back to. I felt like during my childhood, I couldn't be jolly. I feel like my childhood was robbed. This is trauma, I truly believe that. [Participant 9]

Some of the women spoke about the significant role that grandparents played in caring for, protecting and in some cases raising them as young children due to the absence of one or both parents. Other women recounted how their parents' capacity to parent was challenged by their own substance use and related issues and as a result some of the women were raised by another family member including grandparents and aunts:

My aunty reared me. My mum's sister. I lived with her for a long time, yeah. Between my nanny and her. When my ma didn't want me around, I was with them. I was with them most of the time. [Participant 1]

Bereavement and loss of a loved one

Experiences of different and many trauma events, not just in relation to exposure to parental substance use and the impact of that use on them as outlined previously was identified. Loss of loved ones were described as traumatic and connected to their substance use initiation pathways with eight women recounting how they were bereaved by the loss of a close family member, in some cases a parent or sibling:

I found my mother dead in our home; I was traumatized from it. I started taking 2ml of methadone to get asleep at night because I kept on thinking about finding her. And then I went from 2ml to three to four to five to holding me through the day. And then I just thought I needed it. [Participant 10]

The death of a grandparent was also significant and traumatic as encapsulated by one woman:

When my nanny died, that was a trauma for me. My nanny died when I was 18, and I truly believe this, because a lot of people I hung around and went dancing with were taking a few lines, but I was really anti heroin so me nanny and granddad, that's how they played such a huge role in our lives, because, obviously, they knew she wasn't well, and she used to collect me from school, bring me to their house. [Participant 9]

Substance use initiation and pathways

All of the women recounted how they began using drugs from a young age. 11 of the women reported first use before the age of 15. Initiation patterns were described as being connected to their early life experiences and related to exposure to parental and familial substance use:

Well, I suppose, my addiction, I would've started off at quite a young age. When I was probably around the age of 10 or 11, I would've started drinking. And at the age of 11 or 12, I would've started drinking more frequently at the weekends then. I would've started secondary school when I was only 12, so it kind of started off drinking every weekend, and I was smoking hash every day, and it just progressed. It started off smoking hash the other time, then it progressed, and very quickly I was smoking hash every day, by the age of 12 or 13. I was 15 when I started taking drugs in the first place. Ecstasy. No-one had a chance with them raves, and we were all kids. [Participant 4]

Most of the women understood that their initiation into substance use was connected to the trauma they experienced at a young age which they attributed to their exposure to and experience of parental substance use:

Because some people, have been in an alcoholic family or their parents were addicts like me own, as I said. And they end up going out and using drugs for that, because they're escaping from that trauma. They could have been abused at home, all that type of stuff. Because I've heard loads of people speak about it. They go out, they use drugs and then they end up in more trauma because they're caught up in the addiction. Whereas if there's somewhere for them to go about the trauma that's just going on in their home, they might not end up on drugs. [Participant 7]

For many of the women it was evident that substance use initiation and progression was intertwined with intimate relationships in late adolescence and early adulthood. A number of women described being manipulated or 'easily led' (participant 6) in early relationships, and for some this progressed quickly into dependence:

I started using drugs with my friends when I was about 15. Smoked heroin first. And then that was more of a socially thing with my friends back then. But then I got a bad habit when I met a fella who was only out of prison. He was 24 and I was 17. He was only out of prison. We were in a relationship. He was injecting me with heroin. [Participant 2]

Many of the women identified having multiple relationships that they experienced as being unhealthy, and relationships centred around drugs and drug use:

And then a new relationship, which was nearly as disastrous as the first one, so it was just a house with three people in it, all of us doing drugs and drink, and are manic and chaotic in our own ways. And then that house just turned into a drug den. [Participant 9]

Some women reported that they left school early, unable to sustain school going due to the issues they experienced at home, including their parents own problematic and dependent relationships with substances and the impact of their substance use on their ability to support and encourage their children into and within the school environment:

When I started on hash, I was about 12, and I wasn't going to school because I was out robbing for money, for food and for drugs for me family. I was robbing money to get drugs for me brothers and drugs for me. Then I started taking tablets at a fairly young age, from about 11 or 12. My ma used to take me out of school, when I was 12, 14, they would take me out of school, bring me down, have me changing all the different things that were robbed. [Participant 8]

Along with leaving the school system at an early age, some women also left home early. Leaving the family home at an early age was both connected to and resulting from their own substance

use and that of their parents. Similarly to the important role that their intimate relationships played with their initiation into and escalation of substance use, peer groups were also connected to initiation and further escalation of substance use:

> *When I was in secondary school and I was with all the people in my class, and even though all that stuff is going on at home, I used to always stay in other peoples' houses, so the girls in the class, I had a girl in the class and she had a single mother, so I remember I used to stay in her house all the time. And then we started smoking hash, and we'd be smoking hash* together. [Participant 5]

For many women alcohol, hash and benzodiazepines were the first types of substances that they experimented with and then used for more sustained periods:

> *I was doing cocaine from 14, I'd say about 14 to 15, when I started doing cocaine, and ecstasy then as well when I was about 14, 15. And then up came the tablets, for the come down. I really enjoyed the tablets, I got quite addicted to tablets like Zimovane and benzos and stuff. And I suppose, throughout my school years, I managed to finish my Junior Cert, and my Leaving Cert, but I would've actually been an addict, I would've drunk every day after school. My ma would give me money to get lunch, and I would keep the money. She'd give me a fiver and I'd buy four cans of whatever was going cheap.* [Participant 5]

Many of the women were using or had used more than one substance at a time, including heroin, benzodiazepines and methadone, for differing periods of time:

> *I was using heroin from 16 up until I was 19, it wasn't every day, but then something happened to me when I was 19 and then I just went off the rails. I started taking tablets. Everything, yeah. It was mostly Xanax because the doctors were prescribing them, and then I was buying Tranax. And then I was using Tranax, crack, and heroin all in one day, and at the same time.* [Participant 1]

Some women were introduced to methadone at a young age, and for some it was the first substance that they experimented with:

> *Well, it wasn't weed at the time. Hash in school, but when I think back to all them girls, they all went off and got married and got jobs. I didn't, and then I was smoking hash, drinking still at the weekends, and then I remember one night I took methadone, me, that girl and another fella, but I was the only one. I took it. I got sick and I didn't touch it again for another good few years. But then I went back to it.* [Participant 9]

Many of the women interviewed were either currently prescribed methadone or had been previously prescribed methadone. Some women were taking methadone for periods in excess of 20 years:

> *Before I knew it, I was on a clinic at 18 years of age. My mom brought me to a doctor and they sent me down to a clinic. And back then it was kind of you were told it'd be only six weeks, and now it's 26 years later.* [Participant 11]

2. Crack cocaine use

This theme outlines specific aspects of women's crack cocaine use, including initiation into use, their patterns of use and some of the immediate consequences and impacts of using crack cocaine.

Initiation of crack cocaine use

There were variations in the crack cocaine initiation and escalation patterns of the women with critical factors including local markets, peer relations, a traumatic event and the nature of intimate relationships. For a number of women, the onset of and escalation of crack cocaine use was attributed to being repeatedly offered crack cocaine locally, along with an accessible and visible local crack cocaine market:

> *How I got really bad on it was because people couldn't leave me alone to go to the shops. They sell it at my front door basically. People that knew me knew I was on it. They shouted my name up to my apartment. If they had crack, I started letting them in. They started coming into my home.* [Participant 2]

> *I got rid of my mobile phone because I was getting text messages, "lovely crack there," and then it puts it in your head, and then you want it.* [Participant 3]

Some women had experience of having used crack cocaine several years ago, with a break and then re-established their use of crack cocaine again more recently:

> *I started using crack about four years ago. The woman I used to buy my stuff [heroin] off, she was really strung out on crack, and I'd be up in her house, so I just started.* [Participant 1]

> *Last week I met a man that sells it, and he beeps, he makes sure you're hearing him, you know? But I see him wave at me. And I get paid today, money in your pocket and the anxiety. And I kept saying, "Keep walking, just keep breathing."* [Participant 8]

Like their trajectories into use of other substances, traumatic events surrounding bereavement and loss were identified as associated with initiation into crack cocaine use with a number of participants talking about how it was a way to deal with their grief:

> *My father was dying at the time and a friend of mine was smoking it at the time. Of course, I ended up walking in on top of them smoking and I was curious about the drug and wanted to know why they were all so fascinated about it. And I tried it and it was from then on that I just couldn't get away from it.* [Participant 10]

Intimate relationships with a male partner were also identified as critical with respect to both the onset of and further escalation of their crack cocaine use:

> *I met a partner that smoked crack cocaine. But he didn't drink or take coke. In my head I thought this is going to be a great relationship. He'd have his crack, I could have my low-alcohol wine and within two weeks of me starting to drink, I was smoking crack with him. He told me that it was the same as coke, it was just washed up. So, within two weeks I was smoking crack. That was from the age of 19, up to 35.* [Participant 6]

Patterns of use

The amount of crack cocaine used varied depending on factors including access to the substance and amount of money available to pay for crack cocaine. The frequency of use varied from daily use, 3 times per week and weekly use. The typical pattern of use was once or twice per week until it escalated into daily use. Some women reported how they used crack cocaine or how their use of crack cocaine escalated when and if they didn't use other substances such as prescribed or un-prescribed benzodiazepines:

> *I smoked every day since I started on it because I know I wasn't taking the tablets. I don't smoke crack every day, not every day, but more or less every day. When I do it is mostly 3 rocks per day.* [Participant 2]

Some women used crack cocaine daily, some weekly and for some the amount and frequency of use depended on whether they had access to the substance or to money to buy and pay for it. One woman explained the escalation in her use:

> *It was over the last few years that it became an everyday thing, and just wanting it every day. I'd smoke anything from one rock up to whatever I could afford, 20 rocks, maybe, or whatever I could afford in the day. And if there was two or three of us that got paid on the same day or whatever, you know that way, we'd buy a load of it.* [Participant 5]

Some women explained that the pandemic was a factor in the escalation of their crack cocaine use:

> *I was clean at the start of the pandemic. I wasn't taking crack. I hadn't done it for about a year before the pandemic but then when the pandemic came, I had nothing to do. It just started off.* [Participant 12]

All women reported that their use of crack cocaine was in addition to their use of other substances. Crack cocaine was used along with a range of other substances including alcohol, powder cocaine, benzodiazepines, heroin and methadone:

> *I used everything. Anything I could get my hands on. But my main drugs were heroin and crack. I thought that I'd end up dead with the way I was mixing everything.* [Participant 1]

Women spoke about how they viewed their use of crack cocaine and its impacts as being different to that of heroin and powder cocaine, particularly regarding progression to dependency and relapse:

> *The night I tried it, I was hooked. Hooked. Yeah. It's so addictive, it really is. It's really bad. And I know, as I said, there's girls that really go to hard places for it. And you seem to walk around with your head down. I know we walk around when we're drug using with your head down. You're not looking up, but when you're on crack you have that too.* [Participant 7]

Immediate impacts of use

Women also highlighted the ways in which they experienced several impacts arising from crack cocaine, impacts that differed regarding their use of other substances like heroin, methadone and crack cocaine:

> *My ma used to say, "I'd rather you take heroin than that other stuff," which was crack, or cocaine. It was more when the crack came, that I really went off the rails. It wasn't good*

with the heroin either, but I was more able to contain it, with the crack, you couldn't. You just keep going and going and going, 'til you have nothing and there's no other options. [Participant 9]

With the methadone, I was still kind of functional in a sense. I was able to work and was doing relief work … I was able to kind of manage that a little bit but with the crack all bets were off. [Participant 11]

The ways in which women paid for crack cocaine was a key consideration for them. They recounted how they paid for crack cocaine from their weekly social welfare payments, taking out loans from credit unions, borrowing from family and friends and running up debts:

If I got paid on Monday, I'd get it that day. Then whoever got paid the next day, they could buy it that day. And there was only a small kind of group of us, but we kind of got paid, someone got paid on a Monday, Tuesday, you know that kind of way. So, we'd all have our different days to take turns. We'd take turns on who buys what on what day. [Participant 5]

Some women spoke about how challenging it was to ensure that their basic needs were met on a daily basis and how they became vulnerable in other ways including not being able to buy food and pay for utilities such as light and heat, when they were using crack cocaine:

I've been in places where I've smoked crack for a few days and you're like, "Jesus Christ, I haven't slept. I haven't ate". Why did I think I was okay? What was wrong with me? [Participant 1]

Most of the women were currently prescribed methadone or had previously been prescribed methadone from a clinic or GP, while also using crack cocaine. Women were aware of the implications for them when and if it was discovered that they were using crack cocaine while also receiving methadone:

I had to go back on dailies. I was on weeklies because I was stable beforehand, and I had to go back on dailies. [Participant 11]

I used to be with my friends and partner and between me and him, we'd do 10 rocks a day. And then when I was on the clinic, I was only doing one rock a week, because I had to give urines. So, when I got me weekly takeaways, I'd have a rock, and then I wouldn't touch it then till the following Wednesday. [Participant 3]

Avoiding or attempting to stay clear of and away from particular people in their lives and within the wider community was a key strategy some women utilised to avoid using or to manage their levels of crack cocaine use:

I don't miss it [crack] now. I get an odd craving now and again, and I just couldn't be bothered, I keep away from everybody now and keep myself to myself. [Participant 3]

This resulted in feelings of detachment and isolation from others within their immediate and extended family units and within the broader community:

I don't really talk to other women anymore. I feel like I'm detached from the whole world. I suppose it's that I've stopped any other connections in my life. I've stopped linking in and I've stopped trying. It's very hopeless when you are caught up in that heavy crack addiction. That's the way I do feel now. [Participant 12]

> *I didn't want to face life. I'd sit at home and the shame of having to look at every one of your family members and think, "God, are they looking at me like I'm a crack head"? But I was a crack head, I am a crack head*. [Participant 13]

Further escalation of their use of crack cocaine resulted in women becoming further isolated in their crack cocaine use as they tended to use alone rather than with peers. Lone use was seen as a serious escalation and was perceived to be associated with or indicating addiction to crack cocaine:

> *Towards the end, I got so greedy that I didn't want to share with anybody. That's the way the drug had me. At the start it was kind of I had a friend, and I was dabbling with him, kind of in and out, we were using together on and off. It was a really isolated kind of place for me*. [Participant 11]

3. Health and Social Implications

The research findings highlight several ways that women were negatively impacted by and throughout their crack cocaine use. These impacts referred to the ways in which their physical health, mental health and well-being was adversely impacted; housing and homelessness issues; disrupted relationships including relationships with their children; incarceration; and involvement in acquisitive crimes. Each of these will be discussed in more detail.

Physical and mental health implications

Women were physically impacted by their crack cocaine use in several different ways, including strokes, heart attacks and weight loss which often resulted in emergency hospital admissions:

> *I should have been hospitalized. It was just that I didn't call an ambulance. I mean, I was dehydrated, my body dehydrated. I had to go on the drinks because I couldn't actually even chew food anymore. Right. And if I stood up and walked from here to there, I was out of breath. And now I keep thinking, "I should have fucking got an ambulance because I would've got the break, I would've got into treatment"* [Participant 12]

> *I was 36 years of age, I had a massive stroke, blood clot in my brain, hole in my heart, all from the crack. And then they put me in the ambulance, they [the paramedics] saved my life*. [Participant 13]

Many women described breathing problems and being admitted to hospital due to physical complications arising from their use of crack cocaine. Alongside their physical health complications was the fear they felt that a medical practitioner would discover that they were using crack cocaine:

> *I had breathing problems. I was on antibiotics, my lungs went. I had to get antibiotics, the pain, you know through my back and through my chest. And I had to go to the doctor then. And I was like, "What if she knows? What if she knows that I'm on crack?" And then I was like, "She knows, she knows." And that's what happened the first time we ever smoked it, that's what happens*. [Participant 6]

Women were negatively impacted physically due to a lack of food and nutrition which they attributed to spending money on and use of crack cocaine. Health and physical well-being were impacted given what they reported as significant weight loss resulting in reduced energy and motivation to go about daily routines:

> *Thank God I don't have kids because I wasn't even hungry, so I didn't give bollocks about nothing. And that's just not me. I always had money, paid all me bills, had extra money and I was always sensible paying the bills, paying the rent and then doing whatever with the rest until I introduced myself to that drug crack. I didn't give a care in the world. I had no food in the fridge or freezer, nothing. That was never me. I used to always have food and goodies*. [Participant 13]

Contracting infections like Hepatitis commonly occurred with their crack cocaine use:

> *Well, from crack, I contracted hepatitis C, because I just wasn't careful at all, but thankfully I got treatment for it a couple of years ago*. [Participant 9]

An overwhelming sense of a lack of self-care and how their basic needs were not met due to their use of crack cocaine was reported:

Physically, like my lungs collapsed. I had my lungs collapse. As I said, I was in and out of ICUs. Because of the pneumonia and the crack cocaine. I lost weight, I wasn't washing myself, I wasn't eating, I wasn't sleeping. I wasn't looking after myself. I didn't kind of care about myself. It' just stressful. It was horrendous [Participant 11]

Along with their physical health complications, most of the women identified that their mental health was also negatively impacted by their use of crack cocaine. Negatively impacted mental health and overall psychological well-being was a significant consideration for the women:

*It's [crack cocaine] after fu**ing my head up. And that's the truth. It really has. It feels like I'm going to be stuck like this forever, I feel like this for two years. Always on edge. Even though, I'm on all that medication and spent time in (name of hospital). I'm after having two nervous breakdowns since the last two months. I had a heart attack. Heroin never done it to me in 20 years. That [crack cocaine] done it to me in one year. It's mad. A horrible drug.* [Participant 2]

The women reported feeling totally consumed by crack cocaine and the overwhelming impact the substance had on them both physically and mentally:

The mental health is like a bleeding nightmare. I think it's because you're constantly thinking about crack and you're constantly thinking, "How am I getting money for it and this and that." And when you haven't got it [crack], then your attitude, it is snappy and that type of stuff. Well like that, it just brings you to skin and bone, your face gets sucked in. As I said, you walk with your shoulders and your back from midway bent over, and you get scabs on your lips. [Participant 7]

Episodes of psychosis, attributed to their use of crack cocaine, and requiring psychiatric treatment in a hospital setting was reported:

*My mental health, was really, really affected, I was in psychosis, in hospital a few times, in psychosis because of using crack. I never experienced that with my heroin use. I found with crack cocaine, when I didn't have it, I was really fu**ing suicidal. And it came to a stage where at least once a week I was getting detained under the Mental Health Act. I mean, sometimes, they might detain me and then let me out. And I had numerous stays in hospitals. At one stage, I ended up in hospital for three or four months*. [Participant 3]

Feelings of low mood, depression, anxiety and low self-esteem was reported as impacting their sense of self, value and worth throughout the time that they used crack cocaine:

*Feeling unworthy. You know and feeling that you're a piece of shit. Because I think it's a head job. I know cocaine is known as a head job, but that f**king crack is strong. I was just crippled with anxiety. My mind just wouldn't slow down.* [Participant 6]

And it really is just, it's very hopeless, kind of, when you're caught up in that heavy crack addiction. That's the way I do feel now. [Participant 12]

The resulting feelings of low mood, depression and anxiety from using crack cocaine was also associated with episodes of self-harming:

I went missing for ages, I went missing for a good few days, I didn't come home. For a good few days, I was out on a binge, and I was in a really bad way. I had stabbed myself in the foot. I had self-harmed really bad. On this binge, I was in and out of hospital, in and out of hospital. Then every time I'd get let out of the hospital, I was going back and getting

more crack, and then going off my head. I basically lost everything. My mental health was just on the floor. [Participant 3]

In addition to self-harming, feeling suicidal and attempting suicide was reported. Some of the women had more than one suicide attempt, resulting in hospital admission and in some cases repeated admissions, for brief periods:

> *When I wasn't full of something [drugs] I was just utterly, utterly depressed, and just felt awful about myself. I just felt awful about myself. I just didn't feel human. I just, when I think of the stuff I was doing, this stuff I'd settled for with men, I was actually suicidal numerous times, to be honest with you, and actually, the end of me using was the suicide attempt. I would just want to die, and that's what I wanted, because at that point I was like what's the point?* [Participant 9]

Some women reported that the prescribing of and consuming of other medications like antidepressants was a response to feelings of depression, low mood and anxiety which they perceived as arising from their use of crack cocaine:

> *My mental health was very bad. Really bad anxiety, and just fatigue, no motivation. I'd go to the doctor, and I was offered antidepressants numerous times, I think twice I took them for a period of time.* [Participant 9]

The impact of crack cocaine on the women's mental health was not considered to be taken seriously within medical settings or responded to empathically. Women believed the lack of response and empathy was because the deterioration in their mental health was attributed to their use of crack cocaine:

> *It's been a good few years since I've been in there [mental health facility]. Well, I mean, even in there, they just say, "You know, you don't have a psychiatric problem. You have a drug problem." I used to wish they could tell me I had something. You know what I mean? They'd say, "there's nothing else we can do for you unless you actually have a psychiatric problem."* [Participant 12]

Disrupted Relationships

For many women an implication of crack cocaine use was that their relationships with children and other family members became disrupted and damaged which further impacted them mentally and emotionally:

> *My mum and all my family used to walk by me on the street. My ma used to say, "How can you even walk? You're in such a bad way." To think of what I've done for crack.* [Participant 1]

> *I'd lost me ma, me da, me son. I'd lost everything. Me home. Everything. And it's only in the last, not even a year now, that I have me new place.* [Participant 10]

For some, their children entered the care system as some of the women found that they were unable to care for their children fully while using crack cocaine:

> *I ended up doing more and more crack, and then the kids went into voluntary care with their aunties*. [Participant 4]

> *It was horrible, it was. But I know now that it was the right thing. The main reason for that was because in my crack cocaine use, I was quite suicidal, so I had several attempts, and*

> *I was doing a lot of self-harming. So, they were afraid I would do something when I was on me own with the child. And so, I can understand now where they were coming from, but at the time I couldn't see it. I didn't realize everything I was saying, the way I was reacting and everything was just contributing even more to getting him taken off me.* [Participant 6]

A desire to mend relationships with their children and other family members, and to have access to their children were reported as important:

> *I really want the relationship with my daughter. When I was on the crack I lost her.* [Participant 8]

> *So up until that point, when I had my son with me, I felt that my son held me together. But once my son went, I lost everything. I knew I needed help*. [Participant 10]

The desire to be a mother and to rebuild relationships with their children was felt to be challenging as they explained how their own experiences of mothering impacted their capacity to be a mother, particularly what they understood to be a 'good mother':

> *Even my family, they couldn't understand it, but I never had a mother figure, so I didn't know. And still to this day, I don't know what I'm doing*. [Participant 1]

Housing and Homelessness

Housing and accommodation were reported as being impacted by crack cocaine and for some women this included having their homes taken over by crack cocaine dealers:

> *I had to hand the keys of my home over to the corporation because people got into me home and overpowered me. I was five stone in weight, and my family took me out of the home, brought me to hospital. I didn't stay in hospital. Me family took me back home. I handed over the keys to me property to the corporation*. [Participant 10]

> *It was just through people that were around, like I lost my home. The flats were still up. I had been moved into one of the new places and lost that from letting dealers that were starting to bag up crack and that, you know what I mean? The crack was rampant, and I got into debt. And dealers were in and out, in and out, and I got raided. And by the fu**ing skin of my teeth, I got moved.* [Participant 12]

Feeling intimidated, powerlessness and a loss of control over their home environment was reported by the women who experienced a 'hostile takeover' over their homes:

> *There were a few people coming and going into my flat. They were smoking crack in my flat. They were using me to smoke in my flat. And they would say, "What are you going to do about it? What can you do right now, this minute? What can you do? Nothing". I didn't know what to do*. [Participant 2]

> *I nearly lost it [house]. They were taking the house from me because I was letting people use drugs in it. The big guys were using it*. [Participant 8]

Surrendering keys to a house or apartment was often in place of accommodation in a hotel for homeless individuals and families:

> *They [housing service] offered me a hotel. I said, I'm not taking it because you'd be seeing it [crack] going in out your door every day. So, that was a no-go. And where I live, there's*

dealers everywhere around. Everywhere around. You only have to walk outside your front door, and you get it [crack]. So, you get it delivered to you. Make a phone call and it's delivered to you. [Participant 3]

It became challenging to live in and to return to their own communities post residential drug treatment identifying this as a high risk due to the associations with crack cocaine and a vibrant localised crack cocaine market:

If I had of went in somewhere that would have been fine. But it's coming back here again, you're back to square one. So, I'm actually putting in for a transfer to move from where I live as well. But they're only offering me a one-bedroom apartment, and I need a two bedroom. [Participant 12]

Crime and Incarceration

A financial debt owed to crack cocaine dealers posed a strain and stress on the women. Different means was identified to pay off or reduce this debt and included borrowing from family, lending institutions, or using income from employment or social welfare payments:

I'm borrowing down at the credit union to pay off my debt and to pay off the credit cards. By the weekend I was back out doing it again. So, it was like a viscous circle. I got myself into serious amounts of debt. I was at the stage of losing my job. I arrived at work one day and they sent me home, suspended me for two weeks with pay. [Participant 6]

While for others this involved criminal behaviour:

I suppose, robbing money or getting lent some money, robbing from family and friends, robbing stuff out of shops and selling stuff. Yeah, anything really. [Participant 5]

Involvement in crimes such as shoplifting to maintain their use of the drug or to pay off an already existing crack cocaine debt was typical for many women:

For all the years I was on methadone and heroin, I never went to these lengths. I was out shoplifting, and I got a prison sentence. With the crack cocaine, it was kind of the obsession in my head was always there, was constantly there, I just couldn't stop. Then when I was using crack cocaine, I'd be thinking about when I was getting my next rock. Just the power of it is crazy. [Participant 11]

Involvement in drug selling because of their own crack cocaine use was also reported by many women:

When the recession hit and all, I was kind of selling. I had only been selling a few times. [Participant 4]

Time spent in prison due to their involvement in selling drugs and stealing was reported. For some women this was the first time that they had been charged and incarcerated while for others they had been in prison several times:

I ended up getting locked up. I got five years for shoplifting. They let me out and I was meant to do the drug courts, and I didn't do them. I was hectic. I mean, I was fecking hectic at the time. I was never locked up in my life until the crack. I wouldn't have had any charges or anything. [Participant 4]

4. Experiences and Identities

The women identified a number of issues in relation to their crack cocaine use that had specific implications for their sense of safety, their sense of self and also how they perceived they were viewed by other. These included aspects of intimidation and stigma, which are outlined below.

Intimidation

The selling of crack cocaine within close proximity to their homes added to the intimidation they felt. The closeness of crack selling hot spots to their homes made it more difficult for women to avoid; and also added to the intensity and escalation of their use:

> *That's how I got really bad on it because people couldn't leave me alone to go to the shops. They sell it at my front door basically. People that knew me knew I was on it. They shouted my name outside the apartment. If they had crack, I started letting them in.* [Participant 2]

Women felt powerless to those selling crack cocaine typically male teenagers, feeling that sellers had control over them and felt inferior to them:

> *The people that sell it to you look down their nose at you. And they're only kids. I'm 47, 48 this year, and these are 16- and 17-year-olds that are selling it. And they're cheeky little fu**ers with you. It's not nice getting served off a child. And then they're telling you to f**k off, they're not taking the change off you and all this and being smart with you. "Take what you're given". And they don't say very much to fellas, but they say it to the girls. They're probably afraid the fellas will turn around and give them a box. It's degrading, it's a horrible drug.* [Participant 1]

The women were fearful of male dealers selling crack cocaine, feeling that their safety and well-being was at risk:

> *They think they can have anyone. The ones I know that sell think that they can buy anybody. They think they can, basically, have whatever they want. I just think it's people's welfare. Worrying. Yeah, and then I still go, and f**king buy it off them.* [Participant 2]

Exploitation

Some of the women reported the exploitative nature of their relationships with different men in their lives, either through intimate relationships with men or by men that were selling crack cocaine to them:

> *I remember leaving that house and it was said to me the next day, "You need to get away from him, he's going to bleed you dry." I had nothing left. This is why I was sitting in a crack den, morning, noon and night." And that always stuck with me.* [Participant 6]

The women felt shame and embarrassment, not just because of their use of crack cocaine but also due to the interrelatedness of crack cocaine use and other behaviours which included dealing, robbing, prostitution and exchanging sex for crack cocaine or sex for money for crack cocaine:

> *It's shame, guilt, embarrassment, but most girls are in the same situation. They've all been through a lot of shit in their addiction, and we've done a lot of shit as well like selling themselves. And to open your mouth and actually say it then jumps back at you.* [Participant 7]

Personal experiences of prostitution and transactional sex as the means to buy and use crack cocaine was reported by some women:

> *Like, I don't do what I used to do. I used to basically provide a lot of sexual favours for crack. I don't do that anymore. The truth is, yeah. Switch off your brain for a few minutes and it's quick, it's done.* [participant 12]

Engagement in transactional sex for all of the women was specific to crack cocaine use:

> *I was in my late 20s, 30, before I'd done anything like that [prostitution]. It was predominantly when I found crack, after a couple of years, but you can see in this day and age now, there are[women] sleeping in tents, they're sex working from tents. It's not going to get any better, if there's not something done. It's getting worse. In the end I prostituted as well. That's the sort of stuff I used to do, I had to do*. [Participant 9]

A heightened visibility of prostitution and transactional sex within the community and knowledge of women within the community engaged in prostitution and transactional sex was reported:

> *Girls that you know would never go out and sell their body would sell their body and there's and it's horrible to say, but it's very true. Some women will do anything for anyone to get that rock. I talked to the girls in the community. They tell me they're doing it. They tell me. Talked to a girl a few weeks ago and that's what she has to do to get crack. They end up having sex and then they get the free crack. It's happening a lot in this community. It really is*. [Participant 7]

Some women described their involvement in prostitution not just to have access to crack cocaine for their own personal use but also to provide a male partner with access to crack cocaine. The interface between their relationships with men, prostitution and drug relationships was evident for women:

> *I just couldn't manage it [paying for drugs] myself, so I would always find a man to provide in some form or other. He would be of use in some way, and then, if I didn't, I would just go and sleep with somebody, or whatever I'd do with them for money. That was probably the lowest point in my life now. That would have been when I was really stuck, so if the partner I was with at the time was locked up I'd find somebody else, do you know what I mean? [Participant 9]*

Involvement with transactional sex and prostitution negatively impacted the women on a psychological and emotional level:

> *With the sexual favours that just makes you hate yourself. And like to humiliate you, and you know, you're not even looked at like human by someone. Do you know what I mean? And especially if you're like me, aware of it, you're like- "Why did I let myself get this way?*

*What the f**k? I just did it for f**king crack, and it doesn't even give me a break from reality? [*Participant 12]

Stigma

The women felt stigmatised by people around them, including intimate partners, family members and from within the wider community. The women also felt judged from within their community for using crack cocaine:

> *Especially in the last place I lived in, I'm not actually a trouble-making person that doesn't give a shit about anybody, but I was judged so bad. Like that crack head. Oh, she's a prostitute. You know what I mean? Horrible. [Participant 12]*

Women felt that they are treated differently and looked upon differently than men who are using substances. Intense feelings of guilt, shame and embarrassment resulting from their use of crack cocaine was reported:

> *I feel guilt, shame. You know my mind is what suffered the most because my mind wouldn't let up. It's like you're a scumbag. And that's where I think it's different for a woman. It's because we hold onto things more because I was raised really well, and it's like you know, you're a lady, and you're out, and you're selling crack. [Participant 6]*

Specific stigma was associated with crack cocaine compared to other substances, with women using crack cocaine and being labelled a 'crack head':

> *It's shameful walking around, people know that you smoke crack. And there's a shame on that when there's a certain crowd you're walking by. Do you know what I mean? They look at you and go, "Oh, there's that crackhead." It's not nice to be named a crackhead* [Participant 10]

Feeling shameful about buying and using crack cocaine was found to negatively impact their confidence, self-esteem and values:

> *It [crack cocaine] took away my confidence, so I'm not able to really talk around people. I'm starting to get my confidence back a bit*. [Participant 3]

> *People are walking around, like the way it was years ago. Like death warmed up. What happened was when I started the crack cocaine, I was going scoring off them young people that I used to look after. So that's helped me values and my morals go really low.* [Participant 11]

Stigma held the women and typically holds women in a place that they believed did not support, encourage, or aid recovery:

> *The stigma and the shame holds me in that place of secrecy. You're not going around telling people that, do you know what I mean? I'm telling you for the purposes of this, because it's huge and I see it every day, all the time. That's still ongoing. What's actually happening is the girls are getting younger, that are doing it. They're getting much younger.* [Participant 9]

Engaging with and accessing treatment and recovery and broader health and social care supports and services was also viewed as stigmatising:

> *The treatment I got wasn't great. When I had abscesses and things like that, I was treated badly in hospital. And when I had my first daughter, I was treated really badly in the maternity hospital.* [Participant 12]

The stigma attached to crack cocaine and the use of crack cocaine was found to affect their identity as a woman:

> *I keep getting clean and I keep using, so there is no hope, so I felt as if I was hopeless. I didn't feel like a woman, and I felt that I wasn't worthy. I had no life. I didn't have any hopes, I had no ambitions. And then the older you're getting the more you're thinking that's my years of a family gone.* [Participant 9]

Additional layers of stigma were felt as mothers and even more so as mothers who didn't have full time access to their children due to their crack cocaine use. Mothers who didn't live with and have full time care of their children was described as conflicting with how women are viewed and perceived on the basis of gendered societal norms and expectations:

> *I don't have him full time. I only get him at the weekend for now. All because of what women think. Everybody thinks someone should be with their mother and that's it.* [Participant 1]

Some women felt judged by other women particularly when it came to the care of their children and especially if they didn't have custody of their children:

> *Especially when it comes to women with kids. For years I'd be going in and out of court, but purposely messing up my urines. My son is gone five years now and I've been purposely messing with my urines so that the judge wouldn't give him back to me full time because I was afraid of the judgment from other women that didn't have kids and didn't understand. I kept fighting for him knowing that I couldn't look after him.* [Participant 1]

Some women also described an intensified stigma attached to women's use of substances especially during pregnancy:

> *I was using when I was pregnant. That's another thing about stigma as well, going into a treatment centre at 21, pregnant. Obviously, lack of information on their part. But women especially pregnant women are not meant to need a drug treatment centre. Then they started saying social workers will be involved, so I said, right. So, I didn't want to go to the treatment centre and they said, "Well, this is what'll happen if you don't, the baby will be taken off you" so I did.* [Participant 9]

5. Transitions, treatment and support

This section presents the findings regarding women's experiences of exiting their crack cocaine use and the factors that facilitated this or acted as a barrier. All the women had experienced what they described as time spent in treatment and recovery. The women described different types of treatment experiences including residential detoxification treatment and a range of community-based treatments including community detoxification. Fellowship meetings like NA and CA were frequently identified as spaces through which the women were able to maintain recovery and receive supports. Women also described how they supported other women acting as sponsors through fellowship meetings. Several facilitators of and barriers to treatment seeking and accessing treatment were identified.

Gaps, challenges and barriers

Societal expectations of women and in particular women as mothers were described as posing a barrier to women entering treatment along with the need for opportunities to develop trusting relationships:

> *It's just that pressure that people have because of the view that a mother should be able to give up drugs for her child, and it's not that easy. But there should be more help because going into a group, you need to trust the people that's in your group. Slightest bit of doubt when it comes to trust can mess up your recovery*. [Participant 1]

Entry criteria to treatment centres, ability to meet the criteria as set out by treatment centres and waiting lists were clearly identified as posing significant barriers for women using crack cocaine to enter treatment and to receive supports:

> *The process to get into treatment is really tough. Having to get substance free to get in somewhere and trying to do it on your own, on the outside, it's really, really tough, but I did it in the end. There's not enough places to take people in, with drugs in their system*. [Participant 5]

The geographical location of several residential treatment centres was identified as presenting an impediment to treatment and recovery entry and maintenance:

> *I was seeing a counsellor and the only place [treatment centre] she could get me into was a place down (in another city). And I had nobody to come down to me to bring me what I needed so, I didn't go. And I was determined to go at the time, but didn't work out for me, it was a bit far to go down*. [Participant 3]

A lack of treatment and recovery centres that provide childcare supports were identified as a specific barrier to treatment and recovery for women:

> *We definitely need more childcare and support with childcare. If a mother might have a really young baby, funding would be great for creches and stuff. Women, in addiction, could get funding, they might be able to afford to put their child into creche*. [Participant 5]

The women described their treatment experiences with mixed feedback about the need for gender specific treatment centres. Some women expressed the need for women only treatment centres:

I think women treatment centres is definitely a plus.....obviously if you can't get into a women's treatment centre, any treatment centre would do. But I think putting women with women and getting them the support is important. I know when I came into treatment, I needed a lot of love and compassion. Because I hated myself. My self-confidence was on the floor. Woman can build up another woman especially if they have children. [Participant 11]

The women also raised the issue of the need for women only staffing in such centres:

And I'm not sexist in any way, because I trust men, even though they hurt me more so than women, but I think treatment centres that are dealing only with women should have only women staff. I think men should work with men and women should work with women, especially when it comes to issues about that [trauma]. [Participant 1]

Meanwhile others highlighted the benefits of bringing men and women together into a treatment space:

It's great to have men and women put together, because men and women can be support to each other, and women can get to see that not all men are bad. Women need to be able to see that as well, that not all men are bad, and that there are some decent men out there. Because speaking from my own personal experience, and I'm sure a lot of women that would've been in the same place, my experience with men has always been a bad experience. So, getting to kind of be comfortable, or pushing through the feeling and getting to be comfortable, sitting around men and realizing that they're not... I t's helped me grow a bit. [Participant 5]

Low self-esteem, confidence and the ability to ask others for help was identified as creating barriers for women to access treatment and recovery supports:

I don't do CA. I don't do NA. It doesn't work for me. I don't mind going in now and again and listening to the chairs. But I'm not one to stand up in a crowd and talk. I've low self-esteem. And that's one reason why I don't do it. But anything else that has been on course wise, I do do it. [Participant 10]

Other barriers identified by women included women's involvement with an intimate partner who was also using crack cocaine and other substances:

I'm just thinking of a girl there, who had to go back to her ex-partner, who was still using crack, and I watched her go through the process of detox, treatment, meetings, and she was flourishing and she was doing amazing but she had to move back in there with him, and she's back using again. [Participant 9]

The lack of women only groups offering support to women was identified as a barrier to help seeking within the community:

In this area, there's no women groups or anything. Do you know what I mean? I don't know. This is just my perspective. If women groups came together, they could talk about recovery, life skills, normal everyday kind of life skills. For a safe place for women to come. Do you know what I mean? I'm not talking about fellowship. I'm just talking as a group. [Participant 11]

In addition, outreach services were identified as in need of further expansion within the local community:

I suppose more outreach is needed, I needed people reaching out to me.... There needs to be more of that, reaching out, going to clinics, going to GPs. Some people just find it hard to reach out for help, or they don't know the help that's out there. So there needs to be more of the services reaching out to the people, if that makes sense. [Participant 5]

It was recognised that even within existing outreach service provision, gaps remained. Some women identified the positives in the availability of localised street-based outreach but felt that there is a need to extend this outreach to the homes of women, as women are not always visible or accessible at street level:

The threshold can be too high for services. I know there's outreach but some people are not actually on the streets. So that bit, maybe just promote it around the community. I don't know how. [Participant 7]

A number of women believed that there was a lack of sufficient stabilisation programmes and beds through existing services and identified the need to further expand and enhance the opportunities for women to participate in stabilisation programmes were identified as needing expansion:

I know that going in for stabilization should, you might get in for months on end. So, it's like, all right, I stay using till I can get into stabilization. You know what I mean? Or else you have to consider; do I need to come off my methadone to come in somewhere. So, it's like, especially when you've two different things going on, the methadone and crack, they're treated different. [Participant 12]

The need for gender specific treatment centres and fellowship meetings was also identified along with services specifically responsive to crack cocaine use. Supports needed to respond to the issues women are experiencing and have faced due to the intersecting of crack cocaine use and transactional sex, as well as harm reduction services:

There should be much more assistance out there for women who sell sex. You don't want to do it [sell sex]. Women are continuing to use over it, that's why women are using. [Participant 8]

Addressing wider issue of continuing care including housing supports was also a key challenge:

Well, this is what we can do to reduce the harm, and then on a bigger scale we just need more support for women, do you know what I mean? And then continuum of care is huge, because I know from my, and I'm saying this from experience, because housing was my biggest issue every time I went into treatment, because I always have to come back here, and not back here being Ballymun. Here can be anywhere for any different person but I will have to go back to my mother's house, where I did all my using and where she wasn't really in a place to be helping me, and it's not her job. [Participant 9]

The lack of visibility of women in recovery was identified as a gap in current supports:

If another woman comes and says, "Listen, I know what this is like," there's something in that. It's like, well, straightaway, their guard will most likely go down. Not for everyone, and they might be able to sit and talk, and they might be able to find out what you've done and how you could support them, or where they could reach support, or what worked for you, because I know for me, I would listen to somebody that has been there and lived it and come out the other side. Not that I wouldn't listen to a professional [Participant 9]

Gaps in communications and awareness about what the types of services and responses that are available to women to access was highlighted as a cause for concern along with a sense that crack cocaine specific services were lacking in availability to women:

> *Originally, I was treated for my heroin use, but nothing has ever really come around for my crack use, and I have given a dirty urine for the last, probably three or four years. Like years ago, when you presented to a service it would be like "You can get methadone, and we can detox you or whatever." Now it's just, "All right. You smoke a few times a week". And I think if I had heroin urine, she'd say it to me. But because you've coke urine, nothing was really said to you, nothing*. [Participant 12]

The important role of lived experience and the valuable role played in helping people to seek and maintain treatment and recovery through a peer support model was identified as requiring further consideration and implementation at a local level:

> *I think peer support is so important. I see the value of it, and I think it's so important, because when I'm working with the lads and the girls in that job, they will sit down and just chat to me, but if another staff member comes in, you can see the dynamics change, because straightaway their guard goes up and they're thinking, and I used to be the same. They're thinking, "What am I allowed to say? What can't I say? What'll get me into trouble? What won't get me into trouble?" You just go into that state straightaway, without even ... It's not a premeditated thing*. [Participant 9]

Motivations and facilitators for change

The women identified several factors in terms of their motivation to seek and access treatment and recovery supports and services. Previous experience of time spent substance free and the associated positive benefits of same was described as a key motivating factor:

> *I got 18 months clean at the clinic, yeah. It was the best 18 months. I would give up my life so far, just to get a week of the way I felt then. I had a spirit when I got clean off everything, it was magical. Just priceless. They were the best days of my life. I really pray for them. I'm trying, I keep on trying. It's all we can do, you know?* [Participant 8]

Several other factors were identified as being important motivating factors to achieve stability and abstinence from their use of crack cocaine. Factors of significance for some of the women included pregnancy and motherhood. As one woman outlined:

> *I went into residential treatment when I was pregnant, but I really want it again now. Having my son helped to wean me off the crack*. [Participant 4]

For some women, the adverse physical impact of crack cocaine, feeling tired of and feeling like they had enough of it was a strong motivating factor as well:

> *I think I needed to be kind of really broken. I knew after my partner's passing away, like when I was in that place, that I needed to kind of deal with it. So, it was a factor of situations. But I needed to be taken out of society to kind of give myself that little bit of time to kind of slow the hell down. And I did a day program that I had to give two urines, I done a week, and I kind of just went from there, if that makes sense*. [Participant 11]

Some women spoke about how they wanted to stop using crack cocaine because they were no longer experiencing the same positive consequences previously associated with their use:

I got to the stage I got nothing out of crack anymore. I got nothing out, I wasn't getting the buzz, I wasn't getting nothing out, you wouldn't even know I done it. [Participant 3]

Fear of prison was also identified by one woman as a motivating factor to cease using crack cocaine:

And I knew I was getting sent to prison, and I would have end up in prison. I was hurting the people I love, basically. I had to stop [Participant 11]

Peer support and being surrounded by other people with similar and shared lived experiences were described as facilitators of treatment and recovery entry. Fellowship meetings where lived experience is promoted and valued was described as helpful in supporting and encouraging other women through a treatment and recovery journey:

In the NA meetings, I was doing the NA meetings. That was very useful, yeah. That was really useful, because they knew what I was going through. They'd been there themselves, and they didn't give up on me, you know that kind of way? [Participant 5]

Some women described the importance of feeling safe and secure in a treatment and recovery service along with gender specific services being key to facilitating women to enter treatment and recovery services and journeys:

It's in a safe environment that we'll have the gender groups so it'll be women in one group and men in the other group, which is really important, I think, because women do need that space to be able to talk around women issues, the things they can't say in front of men. [Participant 5]

Treatment providers that considered the important role that women in recovery have as mothers was described as an important factor and the need for treatment and recovery centres to consider these roles and for programmes to be designed around these needs. Cutting ties with intimate partners and ending what they described as 'drug relationships' was seen to be important in facilitating change:

I knew I had to ask him to leave. I'm not saying I would've went back using, but I probably would've went back using. So, it was the hardest thing I actually had to do by asking him to go two years ago. When he left, I was like, "What do you want to do? Be yourself now." I started the gym; I lost four and a half stone. And halfway through the gym, I got a good foundation, and I met good girls. [Participant 7]

Discussion and Conclusion

Anecdotal evidence from local drug services since 2017 had suggested that the availability and use of crack cocaine was becoming more widespread across the Ballymun community. A report by O'Reilly and Mac Cionnaith (2019) highlighted the specific patterns, trends and implications that crack cocaine use was having at both an individual, family, and community level. A key recommendation from this report was to explore in further depth the specific experiences for women locally. This was deemed necessary; firstly, as much of what is known about addiction and recovery is dominated by research with men (Monahan et al., 2013); and secondly, as despite the increased availability of Irish-based research examining the use of substances by women (Morton et al, 2023; Ivers, Giulini and Paul, 2021; Galligan & Comiskey, 2019) the national evidence base on crack cocaine use, and specifically use by women is limited (O'Reilly and Mac Cionnaith, 2019). It was also deemed to be a timely research response to this knowledge gap given the increasing availability of and use of crack cocaine (Mongan, Millar & Galvin, 2021; EUDA, 2024) and the ever-growing rates of treatment seeking by women using crack cocaine in Ireland (Lynch, Condron, Lyons & Carew, 2024).

Previous research has illustrated the importance of understanding gendered distinctions with respect to substance use trajectories highlighting the significance of distinct background characteristics including childhood factors, family disruption, childhood involvement with social services, and familial history of substance use (Grella & Joshi, 1999; Boppre & Boyer, 2019). This report has illustrated the experiences of thirteen local women and their use of crack cocaine previously or currently. These experiences are positioned within an overall description of their entry into substance use, and how their initiation pathways were influenced by family, social and community dynamics. The accounts from the women who participated explained in detail their exposure to and experiences of parental substance use, adversity and trauma experienced at a young age and into adulthood as well as how their early substance using patterns were influenced by a sense of normalisation around substance use. These findings reflect what we have learned from existing national and international literature which highlights the interrelatedness of trauma and substance use (Bungay et al., 2010; Ivers et al., 2021; Morton et al., 2023). Understanding how substance use functions as a coping mechanism for the effects of trauma is imperative to developing effective prevention and treatment strategies as intergenerational effects can lock families into cycles of adversity, deprivation and ill health (Montague, 2021).

The participants in this research illustrated the extensive influence of crack cocaine, outlining how they 'couldn't get away from it', 'got a hold' or described it as a 'whole different ballgame'. Several women provided examples of instances whereby its use 'was more intense' than other substances used, where everything was focussed on obtaining or using the drug. Continuous availability and accessibility of drugs in the area, peer influences, and partner relationships were cited as key determining pressures in their commencement with or relapse to crack cocaine. This study also showed the patterns from which women's initiation pathways and use of crack cocaine intersects with other social and personal factors and conditions (Morton et al., 2023).

Women who use crack cocaine have been found to experience a multitude of health problems (Bungay, Johnson, Varcoe & Boyd, 2010; O'Reilly & MacCionnaith, 2019). This report indicates several areas of concern especially relating to women's vulnerability, health and well-being when it comes to their use of crack cocaine. Participants expressed how their physical and mental health were impacted by their use of crack cocaine. For some, new medical and psychological

issues emerged, for others existing complaints or complications resulting from previous use was exacerbated by the use of crack cocaine. A rapid deterioration was noted by several women, as well as increased implications resulting in new hospital or psychiatric admittances or increases in the frequency of visits. Health consequences were reported by women which were more pronounced than those for other substances, interacting with other drugs used and also associated with greater risk behaviours (injecting/sexual) and their related health consequences. Some women highlighted how the use of crack cocaine meant overlooking their own needs. A number of women reported self-harming episodes, suicidal attempts, concerns around physical appearance and its link to mental health challenges, as one participant noting it as an 'isolated kind of place'.

Additional adverse consequences of the use of crack cocaine by women has been documented within existing literature with women found likely to be involved in crime, sex work, the drug economy and homelessness (Connolly et al., 2008; O'Reilly & Mac Cionnaith, 2019). Women in this research outlined their involvement in criminal activities such as shoplifting and drug selling due to a crack cocaine debt, and subsequent involvement with the criminal justice system. The report has also highlighted the lived negative impact on housing and accommodation with descriptions of their houses 'taken over' by drug sellers resulting in the surrendering of their homes and the need to access homeless accommodation supports. Of particular concern, this report has highlighted the exacerbated interrelatedness of prostitution and crack cocaine within the locality as women reported the increased visibility of prostitution. Feelings of intimidation and exploitation by drug sellers and a sense of powerless was common.

It has been argued that gender differentials in crack cocaine use require careful consideration in the development of effective interventions (Risser et al., 2006). A key aim of this research was to further advance and inform responses locally by establishing a knowledge base from which to develop competencies in working with, engaging and retaining women who use crack cocaine in supportive interventions and appropriate services. This research has provided key learnings in what women have experienced as motivators and facilitators to accessing treatment and recovery supports and interventions; and an understanding of the barriers and the challenges that women faced when addressing their support needs. Trauma and substance use disorder presents a complex and intertwined challenge, particularly affecting women who experience unique gender-specific barriers to recovery (Morton et al., 2022; Carter-Orbke et al., 2024). Women in this study identified a gap in women only recovery groups within the community; and expressed the need for greater visibility of women in recovery. It has been argued that women tend to experience better outcomes when they entered programmes designed for women including programmes influenced by trauma informed care (Haseltine, 2000).

Women who use substances, particularly crack cocaine, continue to face considerable stigma. Despite our enhanced knowledge of the impact of stigma on women and their opportunities for recovery, stigma continues to act as a significant barrier to treatment and support seeking. This research has also shown that the stigmatisation of crack cocaine and other substance use by women affects their identities as women and mothers. Crack cocaine use has been found to have a severe impact on the health of the children of those using the substance (Thompson et al., 2010). This research has highlighted the extent of how women's use of crack cocaine impacted their relationships with children and for some this resulted in children placed in the care of another family member. Pregnancy and motherhood, although strong motivating factors for entering into treatment, have also been identified as barriers to women accessing treatment due to their family responsibilities and a lack of available childcare. This report has shown that

children and the desire to have children returned to their care or to increase their access to their children were key motivating factors to seek treatment and recovery. Increased focus on children by treatment services has been advocated for in terms of better outcomes for women and children (Galligan and Comiskey, 2019) but also in recognising the potential for responding to inter-generational trauma and the need to produce better outcomes for the next generation (Montague, 2021).

The report findings extend and elaborate on the previous report 'Crack cocaine use in Ballymun: An Evidence Base for Interventions' (O'Reilly & MacCionnaith, 2019) by exploring more extensively the experiences of women and their crack cocaine use. In examining women's experiences of crack cocaine use, the findings reflect existing research which highlight distinct gender trajectories for substance use, characteristics and progression pathways. The thirteen women who participated in this research provided very expressive, emotional and intense accounts of their journey, key life experiences along the way and related negative or positive influences highlighting further practice and policy areas for consideration and response.

Key Areas for Consideration

1. A responsive policy and practice framework

This research has afforded the opportunity to examine women's prolonged and extensive experiences of substance use against a historical policy backdrop and more recent environment. It conveys the inter-play between causes and consequences of substance use and public policy approaches, implementation limitations or gaps at critical periods. An extended analysis and increased focus on effective public policy responsibilities is required to respond to crack cocaine use among women.

2. A multi-level approach to reducing stigma

The research has illustrated numerous and various layers of stigma which are present for women who use crack cocaine. These are resulting from individual, community factors and the intersectionality between crack cocaine use, transactional sex work, intimidation, exploitation, violence and unhealthy relationships with men (through drug supply networks or intimate partners). Understanding and challenging both visible and invisible stigma through anti-stigma campaigns (such as those developed by Citywide) should be enhanced and further developed.

3. Strategies and interventions to reduce harms and risks

The research has presented a rationale for specific strategies and interventions to reduce risks and harms associated with crack cocaine use among women. These would include having in place specific strategies and interventions relating to the drug type, characteristics of women who use crack cocaine, circumstances of use, risks relating to sourcing and supply of the drug as well as the intense short- and long-term effects and related complications.

4. Addressing the duality of crack cocaine use and mental health

The role mental health plays within the lives of women who use crack cocaine has been clearly depicted and described through the experiences conveyed. The co-existence of mental health and its impact on substance use, crack cocaine use initiation and progression patterns highlights the ongoing and urgent need for the roll out of the integrated model of care under the National Clinical Programme for Dual Diagnosis and widespread implementation of the Seeking Safety model through Seeking Safety Ireland.

5. Supporting treatment seeking and addressing barriers

This research has highlighted that for some women seeking treatment or support services can be difficult and problematic due to the lack of availability of crack cocaine programmes, treatment seeking factors (e.g. childcare, stigma etc.), as well as programme characteristics which can influence participation and engagement. There is a need for further exploration of gender specific and gender responsive treatment, recovery and respite initiatives and facilities. Women also highlighted additional issues which present as people who use other drugs; for example, if they are attending a methadone clinic, citing experiences of efforts to make their use hidden and to keep it concealed for fear of repercussions.

6. Recognizing trauma experiences and effects among women who use substances

Trauma during early life was identified as a key feature of the women's substance use initiations and related to their experiences of parental and familial substance use; domestic violence relating to alcohol and other substance use in the family unit, bereavement and loss of a loved one; and, disrupted familial relationships. Relapse relating to trauma was also cited by some women in the research. The further development and resourcing of local (Trauma Informed Ballymun) and national collective approaches to trauma care in the context of women and substance use, and crack cocaine would deliver responses which reflect current needs and acknowledge the impact on individuals, families, and community.

References

Arpa, Sharon (2017) Women who use drugs: Issues, needs, responses, challenges and implications for policy and practice. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Boppre, B., & Boyer, C. (2019). "The Traps Started During My Childhood": The Role of Substance Abuse in Women's Responses to Adverse Childhood Experiences (ACEs). *Journal of Aggression, Maltreatment & Trauma*, *30*(4), 429–449. https://doi.org/10.1080/10926771.2019.1651808

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Buchanan, J. (2006). Understanding problematic drug use: A medical matter or a social issue? Glyndwr University Research Online: http://epubs.

Bungay, Vicky & Johnson, & Boyd, & Buxton, Jane & Malchy, & Loudfoot, (2009). Women's Stories/Women's Lives: Creating Safer Crack Kits. Women's Health and Urban Life. 8. 28-43.

Bungay V, Johnson JL, Varcoe C, Boyd S. (2010). Women's health and use of crack cocaine in context: structural and "everyday" violence. Int J Drug Policy. 2010 Jul;21(4):321-9. doi: 10.1016/j.drugpo.2009.12.008. Epub 2010 Feb 8. PMID: 20116989.

Burgess, R. (2003). Disrupting crack markets: a practice guide. London: Home Office.

Butler, Shane (1997) Review essay. The war on drugs: reports from the Irish front. Economic and Social Review, 28, (2), pp. 157-175.

Carter-Orbke, M. E., Henry-Okafor, Q., & Moore, G. (2023). Trauma and Substance Use Disorder: Breaking the Cycle in Women. *The Journal for Nurse Practitioners*, *20*(1), 104853–104853. https://doi.org/10.1016/j.nurpra.2023.104853

Collins, P, Carew, A M, Craig, S, Galvin, B, Lyons, S and Quigley, M. (2023) Analysis of the relationship between addiction treatment data and geographic deprivation in Ireland. Drugnet Ireland, Issue 84, Winter 2023, insert, pp. 6-13.

Connolly, J., Foran, S., Donovan, A. M., Carew, A. M., & Long, J. (2008). *Crack cocaine in the Dublin region: an evidence base for a crack cocaine strategy*. HRB Research Series 6. - Drugs and Alcohol. https://www.hrb.ie/wp-content/uploads/2024/06/HRB_Research_Series_6.pdf

Connolly and Donovan, (2014) Connolly, Johnny and Donovan, Anne Marie (2014) Illicit drug markets in Ireland. Dublin: National Advisory Committee on Drugs and Alcohol.

Couvrette, A., Brochu, S., & Plourde, C. (2016). The "deviant good mother" motherhood experiences of substance-using and lawbreaking women. *Journal of Drug Issues*, *46*(4), 292-307.

Covington, Stephanie. (2002). Helping women recover: Creating gender-responsive treatment, in The Handbook of Addiction Treatment for Women: Theory and Practice. Jossey-Bass. 52-72.

Denscombe, M. (2015). *The good research guide: research methods for small-scale social research projects*. Maidenhead: McGraw-Hill Education.

Department of Health (2017). *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. Available from: https://www.drugsandalcohol.ie/27603/.

Ettorre, E. (1992). Women and Substance Use. London: Macmillan Publishers Limited

European Union Drugs Agency (2024). European Drug Report 2024: Trends and Developments | www.emcdda.europa.eu. Retrieved June 19, 2024, from www.emcdda.europa.eu website: https://www.emcdda.europa.eu/publications/european-drug-report/2024_en

European Union Drugs Agency. (2024) Drug supply, production and precursors – the current situation in Europe (European Drug Report 2024).

Fischer, B., Blanken, P., Silveira, , D. D., Gallassi, A., Goldner, E. M., Rehm, J., Wood, E. (2015). Effectiveness of secondary prevention and treatment interventions for crack-cocaine abuse: A comprehensive narrative overview of English-language studies. International Journal of Drug Policy, 26 (4). Retrieved from: https:// idhdp.com/media/400321/ijdpcrackreviewfischeretal2015.pdf

Galligan, K., & Comiskey, C. M. (2019). Hidden harms and the number of children whose parents misuse substances: A stepwise methodological framework for estimating prevalence. *Substance use & misuse*, *54*(9), 1429-1437.

Greenfield, S. F., Back, S. E., Lawson, K., & Brady, K. T. (2010). Substance abuse in women. Psychiatric Clinics of North America, 33(2), 339–355. https://doi.org/10.1016/j.psc.2010.01.004

Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. *The American Journal of Drug and Alcohol Abuse*, *25*(3), 385-406.

Haseltine, Florence. (2000). Gender Differences in Addiction and Recovery. Journal of women's health & gender-based medicine. 9. 579-83. 10.1089/15246090050118080.

Health Atlas Ireland Finder Population Profile (2024) *Community Healthcare Network Ballymun Area Network*. National Health Intelligence Unit Strategy & Research, HSE; Dublin https://www.hse.ie/eng/about/who/healthwellbeing/knowledge-management/ballymun-area-network-population-profiling.html

Hser, Y.-I., Longshore, D., & Anglin, M. D. (2007). The Life Course Perspective on Drug Use. *Evaluation Review*, *31*(6), 515–547. https://doi.org/10.1177/0193841x07307316

Ivers, J. H., Giulini, M. F., & Paul, G. (2021). Supporting women to access appropriate treatment (SWAAT) study. Trinity College Dublin: Dublin, Ireland.

Jackson, A., & Shannon, L. (2012). Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky. *Maternal and child health journal*, *16*, 1762-1770.

Lejuez, C. W., Bornovalova, M. A., Reynolds, E. K., Daughters, S. B., & Curtin, J. J. (2007). Risk factors in the relationship between gender and crack/cocaine. *Experimental and Clinical Psychopharmacology*, *15*(2), 165–175. https://doi.org/10.1037/1064-1297.15.2.165

Lynch, T., Condron, I., Lyons, S, & Carew, A. M. (2024). Drug treatment demand in Ireland 2023. HRB, Health Research Board. Retrieved from https://www.hrb.ie/publication/drug-treatment-demand-in-ireland-2023/

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook (2nd ed.). Thousand Oaks, CA, US: Sage Publications, Inc.

Mongan, D., Millar, S., & Galvin, B. (2021). *The 2019-20 Irish National Drug and Alcohol Survey: Main Findings*. Retrieved from https://www.drugsandalcohol.ie/34287/1/HRB_Irish_National_Drug_and_Alcohol_Survey_2019_20.pdf

Monahan, K. C., Steinberg, L., Cauffman, E., & Mulvey, E. P. (2013). Psychosocial (im)maturity from adolescence to early adulthood: Distinguishing between adolescence-limited and persisting antisocial behavior. *Development and psychopathology*. 25. 1093-1105. doi:10.1017/S0954579413000394.

Montaque, A. (2021). *A Brighter Future. A plan to tackle the underlying causes of addiction and crime and to tackle open drug dealing.* Dublin: Dublin City Council.

Morton, S., Carine Mutatayi, Pálsdóttir, K. I., Nadia Robles Soto, & Cristiana Vale Pires. (2022). *Implementing a gender approach in drug policies: prevention, treatment and criminal justice*. Council of Europe.

Morton, S., Curran, M., & Barry O'Gorman, M. (2022). Adverse childhood experiences, domestic violence and substance misuse: an action research study on routine enquiry and practice responses. *Frontiers in psychiatry*, *13*, 892849.

Morton, S., Gallagher, B., & McLoughlin, E. (2023). *Title "You can't fix this in six months": The intersectionality of women's substance use in the Irish context*. Retrieved from https://www.drugsandalcohol.ie/38492/1/You%20cant%20fix%20this%20in%20six%20months.pdf

Mutatayi, C., Morton, S., Robles Soto, N., Pálsdóttir, K., & Vale Pires, C. (2022). Implementing a Gender Approach in Drug Policies: Prevention, Treatment and Criminal Justice A handbook for practitioners and decision makers. In *Drugs and Alcohol.ie*. Retrieved from https://www.drugsandalcohol.ie/36974/

Murphy, T. (1996). *Rethinking the War on Drugs in Ireland*. Stylus Publishing, LLC.

O'Gorman, A., Driscoll, A., Moore, K. and Roantree, D. (2016) Outcomes: Drug harms, policy harms, poverty and inequality. Dublin: Clondalkin Drug and Alcohol Task Force.

O'Reilly, L., & Mac Cionnaith, C. (2019). *Crack cocaine use in Ballymun: An evidence base for interventions*. Dublin: Ballymun Youth Action Project.

Perrenoud, L. O., Oikawa, K. F., Williams, A. V., Laranjeira, R., Fischer, B., Strang, J., & Ribeiro, M. (2021). Factors associated with crack-cocaine early initiation: a Brazilian multicenter study. *BMC Public Health*, *21*(1). https://doi.org/10.1186/s12889-021-10769-x

Radcliffe, P. (2011). Motherhood, pregnancy, and the negotiation of identity: The moral career of drug treatment. *Social science & medicine*, *72*(6), 984-991.

Rhodes BE, Gottfredson NC, Hill LM. (2018). Desistance and Treatment Seeking Among Women with Substance Use Disorders. Qual Health Res. 2018 Jul;28(8):1330-1341. doi: 10.1177/1049732318767637. Epub 2018 Apr 19. PMID: 29671376; PMCID: PMC7470472.

Rhodes, T. (2000) The multiple roles of qualitative research in understanding and responding to illicit drug use. In: G. Greenwood & K. Robertson, eds. Understanding and Responding to Drug Use: The Role of Qualitative Research, pp. 21–36. Scientific Monograph Series no. 4. Luxembourg: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Risser, J. M. H., Timpson, S. C., McCurdy, S. A., Ross, M. W., & Williams, M. L. (2006). Psychological Correlates of Trading Sex for Money Among African American Crack Cocaine Smokers. *The American Journal of Drug and Alcohol Abuse*, *32*(4), 645–653. https://doi.org/10.1080/00952990600919062

Stone, R. (2015). Pregnant women and substance use: fear, stigma, and barriers to care. *Health & justice*, *3*, 1-15.

Thompson, S. J., Bender, K., Windsor, L., Cook, M. S., & Williams, T. (2010). Homeless youth: Characteristics, contributing factors, and service options. *Journal of human behavior in the social environment*, *20*(2), 193-217.