

Private Lives - Public Issues

An Investigation into
the Health Status
of Female Drug Users

by Marie Lawless

(This report was written and compiled during 2002)

Acknowledgements

Merchants Quay Ireland is indebted to all clients who agreed to participate in the research study and gave so generously of their time and enthusiasm.

Dr. Maureen Brennan for undertaking the medical assessments and investigative tests required for the research project.

Margaret O'Sullivan who assisted Dr. Brennan in undertaking the assessments, and also gave so much in terms of preparing and maintaining the operational features of the Project.

Staff of the Health Promotion Unit, especially Ray McGrath (Service Manager) and Linda Cox (Project Worker) for their role in the development and progress of the research project.

Denise O'Mahoney of Cedar House Primary Health Care Service who offered advice and support within the initial stages of the Project.

Staff in the Pathology Department of St. James Street Hospital especially Professor Rory O' Moore and Dr. White (Senior Laboratory Technician) who facilitated us so agreeably with our research study.

Liam English of the Microbiology Department in St. James Street Hospital for providing advice and assistance regarding the clinical aspects of the study.

To the numerous general practitioners in the area who facilitated us in providing follow-up care of the female clients who participated in the research study.

Frank Mills, Director of Social Inclusion for the SWAHB for his support and co-operation.

Dr. Gemma Cox who was involved in the designing of the research proposal.

The research was made possible with the financial support received from the Health Research Board.

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Foreword

Profiles of individuals who engage in 'problem' drug use have been widely documented as exhibiting low educational attainment, high levels of previous imprisonment, poor social mobility and limited employment opportunities. Similarly, research studies have illustrated the influence of social class on equity of access to and utilisation of health services. By virtue of their drug using behaviour, drug users are at increased risk of acquiring a diverse range of medical complaints than those of the general population. This is further compounded by the fact that their chaotic drug using lifestyles can often pose difficulties when seeking help from within the structures of the medical setting. Although there is a widely held belief that drug users are frequent attendees of the health services, such visits are often reactive to certain circumstances (such as A&E attendance) rather than on a routinely medical care basis.

Consequently, the direct care of these individuals is increasingly placed within the drug treatment setting. It is often the case that drug users' only source of regular contact are with drug services, and as such provide, in some instances, the only feasible option for the drug user. In this regard, drug services are increasingly being placed in a position to respond to various health care needs of their clients. While such activities are essential, few drug service providers are equipped with the expertise and resources with which to undertake this task.

Strategies to encourage greater utilisation of health care services among drug users can only be successful if consideration is given to their individual health needs and circumstances. This action, research project has therefore provided an opportunity to investigate the health status of female drug users, which in the past, have been restricted to studies on drug use and pregnancy. This study entailed the establishment of a Women's Clinic over an eight-week period in which detailed medical assessments were undertaken by a female gynecologist with a cohort of female drug users who were regular attendees of the Contact Centre. This information was complemented by clients' self-reported data on their current health status and previous medical health complaints.

The establishment of a Women's Clinic within the Contact Centre of Merchants Quay Ireland, proved highly successful in initiating medical interventions on numerous levels. For the female drug user, it provided a supportive environment in which to share health concerns, be informed, and in some cases, the means to overcome previous negative experiences within a convenient and highly familiar setting. For Merchants Quay Ireland, a drug service provider, it developed important partnerships with a range of medical services in the locality. On a national level, it affirmed the need for adequate, appropriate and direct access of health services for those who are in greatest need of such interventions.

Executive Summary

In 1992, a Health Promotion Unit was set up within Merchants Quay Ireland to provide a model for working with people who engage in both injecting and sexual risk behaviour. In 1997, it was decided to undertake an evaluation of the Health Promotion Unit during an eighteen-month period from May 1997 to October 1998. One of the main findings of this evaluative research, highlighted that despite the shorter injecting careers of female drug users, new female presenters were significantly more likely to report suffering from a range of physical and mental health complaints than their male drug using counterparts (Cox and Lawless, 2000).

Based on these findings, a submission was made under the Research Project Grants Scheme to the Health Research Board, which was subsequently accepted. This proposal set out to examine the health status of female drug users by undertaking detailed medical assessments in addition to collecting self-reported information. In order to carry out the research, a Womens Health Project was established in November 2001 for an eight-week period in the Contact Centre of the Merchants Quay Ireland. The Project opened one morning a week and operated on a drop-in basis. All participating women were offered a thorough medical examination, smear tests, Hepatitis B/C, HIV, and STI testing, in addition to advice and information and appropriate referrals.

Research Objectives

As stated above, the aim of this pilot project was to examine in detail the health status of female drug users. More specifically, the study proposed to;

- (a) Provide a detailed medical assessment of the health status of female drug users;
- (b) Examine the use of primary health care services by female drug users and to;
- (c) Assess the health care needs of female drug users.

Research Methodology

Both qualitative and quantitative methodologies were used at different stages to investigate the health status of female drug users. The main advantage of combining both quantitative and qualitative methodologies is that it allows a collection of different types of information (Pawson and Tilley, 1997). In order to achieve the above objectives, data was collected by employing the following;

- i) A *Focus Group* was undertaken with a cohort of regular female injectors at the Contact Centre. This was undertaken to ascertain their levels of interest in the research project and based on their opinions to inform the design of the project prior to commencement.
- A *Health Information Form* was administered by a member of the research department to all female clients prior to their medical assessment. This form collected data on socio-demographic information, injecting and sexual risk behaviour and in addition provided self-reported information on female clients' health status and levels of contact with medical services.

- *Semi-Structured Interviews* were undertaken by a member of the research team with all consenting clients following completion of the health information form. These interviews provided an opportunity to gain an in-depth understanding of the women's perceptions of their health status and to examine their experience of primary health care services. Interviews were also conducted with all the staff involved in the delivery of the Project upon its completion.
- A *Medical Assessment Form* was completed by the medical practitioner both during and upon completion of the consultation. Information recorded included details on the medical history of the client and that of their family, past surgical history, past gynecological history, current medication, known allergies to medication, a general medical assessment including a review of systems and any laboratory tests undertaken in addition to follow-up and referral arrangements.

Research Findings

Summary of Results

Client Profile
(n=17)

Socio-Demographic Information

- Over three quarters of the clients were under 30 years of age (n=14; 82%); mean age 26.7 years;
- 65% (n=11) reported being currently 'out of home';
- Clients reported a mean of 2 children (range 1-4 children), with the majority reporting having child-care responsibilities;

Drug Use and Risk Behaviour

- 88% (n=15) commenced their injecting careers prior to 25 years of age, with over a third reporting IV drug use before 20 years of age;
- Heroin was the primary drug of choice, with injecting the preferred route of administration for the majority of clients over the previous four weeks;
- 76% (n=13) were polydrug users;
- 76% (n=13) were currently in receipt of prescribed methadone;
- 47% (n=8) were taking other prescribed medication excluding methadone, of whom 76% were taking this medication in excess of three months (n=6);
- Of those who injected, 36% (n=3) reported injecting in particularly dangerous places such as the groin and the neck;
- 47% (n=8) had a regular sexual partner who was an injecting drug user;
- Of those currently sexually active (n=10), only 30% (n=3) reported the use of contraception.
- Only 18% (n=3) reported ever having had an STI infection.

Physical Health Complaints

All clients reported having had at least one physical health complaint within the last week, with 94% (n=16) reporting a complaint for the last three months;

- 59% (n=10) reported sleep problems;
- 47% (n=8) reported shortness of breath;
- 41% (n=7) reported poor appetite;
- 41% (n=7) reported weight change;

Psychological Health Complaints

94% (n=16) of clients also reported having experienced at least one psychological health complaint within the last three months;

- 82% (n=14) reported depression;
- 65% (n=11) reported anxiety;
- 59% (n=10) reported feeling unable to cope;
- 56% (n=9) reported feeling isolated;

Perceived Health Status

- Only 12% (n=2) reported their health status as 'good' or 'very good';
- 41% (n=7) of clients reported their health as 'bad' or 'very bad';
- 47% (n=8) reported improved general health in comparison to a year previous;

Drug Related Problems - Technique Specific

Of those currently injecting, 67% reported having experienced at least one injecting related complaint, with 56% reporting a complaint over the previous 3 months;

- 45% reported scarring/bruising of the injecting site (n=5);
- 45% reported difficulty finding veins (n=5);
- 27% reported abscesses (n=3);

Blood Borne Infections

- 1 in 2 clients reported having previously being tested for Hep B and C;
- Only a minority reported ever having had hepatitis B (18%; n=3) or jaundice (12%; n=2);
- 65% (n=11) of female clients reported being hepatitis C positive at the time of interview;
- Disclosure of hepatitis status was often as a result of the clients' involvement with various other social services apart from medical services;
- Clients reported having limited information with regard to Hepatitis C;
- 65% (n=11) of clients reported having received the hepatitis B vaccination;
- 82% (n=14) of clients had previously being tested for HIV, the majority within the last twelve months (65%; n=9).

Medical Interventions
(n=15)

Level of Participation

- 88% (n=15) of clients agreed to undertake the investigative screening assessment and tests;
- In total, 33 medical interventions were undertaken over the eight week period;
- There were 18 follow-up interventions undertaken by 11 clients;

Medical Assessment

- 38% (n=6) of clients reported being asthmatic, 19% (n=3) were epileptic;
- 81% (n=13) of clients reported having ever being hospitalised;
- 23% (n=3) of these reported having been hospitalised as a result of suicide attempts in the past;
- 40% (n=6) of clients were noted to have abdominal abnormalities during the review, such as severe indentations and bruising as a result of injecting;
- Only 13% (n=2) of clients were underweight at the time of interview;
- Over half of the clients assessed were either 'obese' or 'overweight' (n=9);
- 75% of clients reported experiencing at least one gynaecological complaint (n=12);
- A large proportion of clients (42%, n=5) reported experiencing secondary amenorrhoea with a further 17% (n=2) reporting irregular menstruation;
- 33% of clients reported having had a spontaneous abortion in the recent past (n=4);

Investigative Screening Tests

- 87% (n=13) of clients requested at least one laboratory test;
- 67% (n=10) of clients had a full blood count undertaken. Of these, 70% of clients were found to be anaemic (n=7);
- 87% (n=13) had positive hepatitis C (antibodies present);
- 13% (n=2) had positive hepatitis B (antibodies present);
- 20% (n=3) had abnormal liver tests;
- Only one client had an abnormal cervical smear.
- No client had a positive HIV status.

Contact With
Medical Services
(n=17)

Access to Medical Services

- 29% (n=5) reported that they had experienced difficulties in accessing treatment in the past;
- 82% (n=14) were registered with a G.P, of whom only 47% (n=8) cited that their G.P was geographically accessible;
- Nearly a quarter (24%; n=4) reported that their medical card was 'out of date';

Level of Service Contact

- 77% (n=13) of clients reported having at least one contact with a medical service provider within the last three months;
- Level of contact with general practitioner and pharmacist was high however; this was due to high numbers in receipt of methadone and other prescribed medication;
- The majority of clients reported a lack of understanding and sensitivity among medical service providers

Medical Sources of Reference

- Clients were asked to report their most frequent source of medical consultation;
- Over a quarter of female clients reported that they would take care of the complaint themselves prior to presentation at a medical service provider (29%; n=5);
 - 29% (n=5) would attend their G.P as their first point of contact;
 - 24% (n=4) reported that they would seek assistance from drugs workers;
 - 18% (n=13) would attend the A&E;
- Clients were also asked the primary means through which they accessed medical advice and information;
- Less than a third of the clients reported frequently approaching various medical service providers (n=5).
 - Nearly a quarter of the clients reported drug services as their source of consultation (n=4);
 - 12% of clients reported having nowhere to obtain such information (n=2).

Recommendations

Developing Women Centered Interventions

- Gender differences in approaches to medical diagnosis, intervention and prevention must be examined and employed;
- Consulting women with regard to their health needs will help develop services which are appropriate to their needs and circumstances;
- In promoting positive health care practices the aim should be to maximise the health of the individual by creating a model to which drug users can relate. Health services, therefore, must be flexible and resourceful to adapt to the differing needs of this client group.

Providing a Continuum of Services

- Work on the basis of a comprehensive assessment of the women's situation and apply case-specific care and treatment planning techniques.
- Linked service model of care, whereby individual case files may be accessible by professionals, would ensure both continuity and follow-on care.
- Adopt a broader focus to health to include access to primary health care, reproductive health services, pre-natal care or behavioural health services.
- Develop a comprehensive hepatitis C strategy which focuses on raising awareness, preventative care and treatment options.
- ® Ensure provision of on-site counselling to deal specifically with psychiatric complaints among this client group.

Employing Health Promotion Strategies

- Routine regular contact with drug users should include running through a health checklist to increase early detection of medical complaints.
- Provide a wide range of health services in a local setting which are responsive to their needs and which are user-sensitive, culturally specific and readily available.
- Regular liaison and co-operation between drug, health and other social services to provide co-ordinated care and follow-up support for drug-using clients.

Increasing Access and Participation in Health Care Services

- Secure funding within all drug services to ensure that a Welfare Rights person is available to inform clients of their health entitlements.
- € Ensure that the process involved in the application of medical cards under the General Medical Scheme is made more user-friendly. In this regard, consideration should be given to reducing the tedious and time-consuming element of both applying for, and processing the card. Extending the expiry period of medical cards is also recommended.
- The provision of drugs awareness training, education and information to health care professionals who work with women who use drugs and drug users in general.
- Drug services should develop and employ specific outreach efforts to draw women into treatment or to direct them towards services that can cater for their overall health care needs.

Promoting Women's Health

- Ensure research findings and policy decisions are turned into effective women's health programmes.
- Develop and implement effective women's health polices and programmes at a local and national level.



Introduction

1.1 Background to the Study

A common theme within the literature is that women drag users are often a hidden or "hard to reach" population (Ettorre, 1992, DAWN, 1994) who experience a range of problems that differ substantially from those encountered by male drag users (Bubble and Woods, 1992; Taylor, 1993; Swfit *et al*, 1996; Copeland, 1997). Most notably, female drag users complain of a range of medical and psychological problems more often, and to a greater extent than their male counterparts (Cox *et al*, 1999). However, very little research have addressed the health care needs of the female drug user. Women who use drags find themselves largely invisible when it comes to appropriate service delivery and social policy responses. It is argued that service responses to women have been largely located within the context of HIV, following concerns over the spread of the infection through childbirth. Limiting the spread of HIV infection has therefore taken priority over the general health and well-being of women. Many women drag users also face difficulties in accessing drag treatment services due to social, economic and child-care responsibilities (Bubble and Woods, 1993; Woods, 1993; NIDA, 1998; Hunter and Judd, 1998; Swift and Copeland, 1998). Moreover, research has highlighted the perceived insensitivity of the drag treatment setting to cater for women specific problems (DAWN 1991, 1994; Thorn and Green, 1996). This pilot project which aims to investigate the health status of female drag users will help to ensure that both medical and drag service providers are responsive to some of the issues that are likely to be of importance for women who use drags.

1.2 Objectives of the Study

The aim of this pilot project is to examine in detail the health status of female drag users. More specifically, the study objectives are to;

- Provide a detailed medical assessment of the health status of injecting female drag users;
- # Examine the use of primary care health services by female drag users and to;
- S Assess the health care needs of female drag users.

1.3 Plan of Investigation

1.3.1 Setting

In order to undertake the above research objectives, it was decided to establish a Women's Health Project over an eight week period within the Contact Centre of Merchants Quay Ireland. This low threshold service was selected as it is often the first point of contact for active drag users which focuses on establishing contact, informal support, crisis intervention and health promotion. More importantly, data collected for monitoring purposes throughout Merchants Quay Ireland has shown that a consistent proportion of female attendees avail of this service on a regular basis. The services offered within the Women's Clinic were to include; a thorough medical examination, smear tests, STI, HIV and Hepatitis B/C testing, Hepatitis B vaccinations, and advice, information and referrals. Initially it was intended that this service would be best provided the morning the

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service is closed for staff training, so as to allow for the fact that that many concerns of drug using women can not be adequately dealt with in mixed settings.

1.3.2 Exploratory Activities

The engagement of female drug users in the establishment of the Women's Clinic was considered to be of utmost importance from the onset. In this regard, a focus group was held with a cohort of female injecting drug users who presented at the Contact Centre of Merchants Quay Ireland, which ascertained their levels of interest in, as well as providing valuable feedback of certain operational features of the proposed project. Based on these findings, certain areas of concern were highlighted in addition to modifying elements of the Project prior to commencement. The main issues presented were;

Lack of clarity among female clients surrounding the intended role of the doctor. Many clients assumed that the main benefits of introducing a doctor within the Contact Centre would be the possibility of entry onto a methadone programme or the ability of the doctor to prescribe other medication. In view of this, it was decided that guidelines on the activities undertaken by the doctor had to be firmly established prior to commencement of the Project and made known to female clients. Additional meetings were therefore held in which the doctor's role in the Project was further clarified and which ultimately illustrated the investigative nature of the research as opposed to its curative role.

A large proportion of female clients reported having no current medical card. As a result, female clients reported that the expense involved often meant poor contact with health services. For those female clients who did report having a medical card, they were largely unaware whether their card was current or not. This was considered to be of utmost importance for the research study as due to its limited time frame, increased emphasis was to be placed on referring clients to specialised medical services following the medical assessment. In response, informational materials and posters were publicised throughout the Contact Centre in order to raise awareness and highlight the importance of acquiring a medical card. In addition, drug workers at the Contact Centre were involved in administering medical card application forms and providing assistance to female clients in completing the forms.

Female clients reported a preference for establishing the Women's Project within the everyday mixed setting as opposed to isolating them further by means of their participation on a morning when the service was known to be closed. This issue highlighted the importance of involving clients in the Project from the onset. It proved highly influential in deciding upon certain operational features of the Project, which could otherwise have impacted significantly on levels of participation in the study.

1.4 Method of Investigation

Prior to establishment of the Women's Clinic numerous meetings were held with a steering group for the Project. This group comprised of the assistant director of clinical services, assistant director of research and development, service manager of the Contact Centre, two female drug workers, one of whom was a nurse within the Contact Centre and finally a member of the research department. Consideration was also given to the recruitment of a female doctor who would be familiar with, and have previous experience of working with this client group. Difficulties in recruiting for this position greatly delayed the proposed start date for the Project. Having recruited a female doctor her involvement in the meetings meant additional issues for discussion were introduced.

- Firstly, it was decided that the provision of hepatitis B vaccinations was not feasible due to the time constraints associated with this work.
- II Secondly, due to the sensitivity of the medical tests being undertaken, the provision of pre and post counselling was considered an essential component of the Project. In this regard, training on both pre and post counselling skills was organised for staff members at the Contact Centre.
- C⁵ Thirdly, it was considered that in light of the importance placed on referrals the following activities were undertaken;
 - *Informed G.P's-* The decision was taken to inform local G.P's of the nature of the proposed project because of the importance placed on referrals and the fact that some female clients may have already

been registered with their own doctor. In this regard, letters were sent out to all G.P's with whom clients were known to be registered with in the locality.

- *Assisted Clients in Obtaining Medical Cards*- Workers at the Contact Centre were involved in administering medical card application forms and providing assistance to female clients in completing the forms.
- *Arranged Referral Arrangements for Persons Without Medical Cards*- Although efforts were being made among Contact Centre staff to highlight the importance of medical cards among their female clients, there was in fact a possibility that some participating clients may not have applied for one, or may be in the process of applying, and so alternative referral arrangements were required for this client group. In view of this, contact was made with a member of Northern Area Health Board who had responsibility for the homeless multi-disciplinary primary health care team. It was therefore decided that these clients, if homeless, could then be referred onto the primary health care team to obtain a current medical card through a fast track system.

1.5 Project Delivery

1.5.1 Planning Phase

The planning and preparation involved in undertaking an action research project was considerable in view of the sensitivity of the intervention and the implications for the female clients participating. It was also necessary to ensure that the delivery of this project did not interfere with the normal daily functioning of the Contact Centre, although specific demands on both human and physical resources were envisaged. Therefore considerable time and effort were devoted to ensuring that the project was implemented and delivered in the most efficient manner for the participating clients and for staff. The following activities were undertaken in the months prior to implementation;

- Recruited a highly experienced gynecologist who had previous experience of working with marginalised individuals;
- Promoted the project among regular female attendees to the Contact Centre;
- Administered and facilitated the completion of medical card forms among female clients;
- Training of staff members of the Contact Centre in pre and post counselling;
- Established contact with various medical personnel and service providers within the locality;
- Established contact with St. James hospital; developing a protocol in accordance with St. James hospital regarding the transport of samples and receipt of results;
- Obtained the relevant and appropriate medical equipment for the project.

1.5.2 Implementation Phase

The Women's Health Project operated one morning a week (Tuesday Morning) on a drop in basis for an eight-week period. The Project was advertised in advance through staff members of the Contact Centre in order to ensure maximum attendance. The recruitment of female clients was further enhanced through the existing rapport already established between the clients and the staff of the Centre.

The Womens Health Project was staffed by the aforementioned staff; a female gynecologist, a female nurse and a female drugs worker. Interested participants were firstly asked to read and sign a consent form which detailed the purpose and degree of involvement required by the client. It was highlighted that participation in the project was entirely voluntary, and that refusal to participate would not influence or jeopardise the service which they receive at either the Contact Centre or any other service within Merchants Quay Ireland. The confidentiality of information provided by the client was assured. In addition, clients were informed of the range of medical tests which they could avail of during their intervention and were asked to select those they were interested in. Pre-test counselling was made available appropriate to the type of tests selected by the client. Clients were then asked to undertake an interview with a member of the research team. Following on from this, clients were then referred to the clinic for a comprehensive medical assessment. As stated earlier, all

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women were offered a thorough medical examination including a range of tests. Upon completion, clients were provided with a health pack to acknowledge and show appreciation for their participation in the research study.

1.6 Structure of the Report

The next chapter examines both national and international literature on the circumstances and needs of female drug users. It will firstly present a review of research on drug use in Ireland and on the socio-demographic characteristics of female drug users. A review of national and international literature demonstrates that female drug users are at increased risk of contracting the HIV virus and other sexually transmitted diseases through injecting and sexual risk behaviour. Literature on the use of primary health care services among female drug users is also examined. Finally, the importance placed on gender specific services in both the national and international policy context is discussed.

Chapter Three presents the methodology employed to research the health status of injecting drug users. It presents an examination into the strengths of combining quantitative and qualitative methodologies in addition to an overview of the role of feminist methodologies in researching women. The design and implementation of research instruments used in the research study are also discussed.

Chapters Four, Five and Six illustrate the findings of the research study. Both qualitative and quantitative data is presented throughout these chapters. Chapter Four demonstrates the client profile of those who participate in the research project, while Chapter Five focuses on the experience of medical complaints and contact with health services among the cohort of female drug users. Results relating to the medical assessments undertaken during the eight-week period will be illustrated throughout Chapter Six.

The Report concludes with *Chapter Seven* which provides a summary of the main findings, and presents the main conclusions and recommendations.

Literature Review

*"Treatment needs, as with other human needs
have a gender related component"*

(Wald, *etal* 1995: 882)

2.1 Drug Use in Ireland

It was not until the late 1970s and early 1980s that the use of illicit drugs in Ireland, particularly heroin, became a recognised social problem. The numbers seeking treatment steadily increased to large proportions throughout the 1980s and 1990s (Butler, 1991). In a five year review of treated drug users, (JHiggins and Duff (1997) reported that in 1995 the total number of treatment cases in Dublin was 3,593, the overwhelming majority of whom were opiate users. This increased to 4,283 in 1996 (Moran *et al*, 1997) to 6,043 in 1998 (O'Brien *et al*, 2000) and 6994 in 2000 (O'Brien *et al*, 2003).

Most of the available Irish data is based on drug users who actually present for treatment and it is generally recognised that only a small proportion of problem drug users are in contact with treatment services (Hartnoll *et al*, 1985). Other studies undertaken in Ireland, and more specifically within Dublin, have tended to be localized, small scale studies. One Irish study has attempted to estimate the prevalence of opiate use in Dublin (Comiskey, 1998). Comiskey employed a capture-recapture methodology using data from three different sources; The Central Patient Methadone Treatment List, the Hospital Inpatients Enquiry Database and Police Arrests. This research estimated that the total number of opiate users in the Greater Dublin Area in 1996 was 13,460.¹ Comiskey's findings indicated that the number of opiate users at that time in Dublin were comparable to those in other European cities. While recognising that drug use is largely an urban problem, research in the U.K has illustrated that within this urban area it is highly scattered and localized, with a tendency for heroin use to be concentrated in certain neighbourhoods which exhibit various indices of social deprivation (Pearson, 1991).

2.2 Drug Use and Gender

Until recently literature on female drug users was sparse, with images of the circumstances and needs of women substance users remaining largely unacknowledged (Cox *et al*, 1999). A central theme in the research literature has been that men predominate in the drug sub-culture and are active users, while women are viewed as secondary and relatively passive participants (Ettorre, 1992). However, contemporary ethnographic studies have highlighted a different profile of the female drug user. For example, Taylor (1993) in her study of a female injecting community in Glasgow describes female drug users as active within a social network of drug

¹ Since the completion of this report, a 3 Source Capture-Recapture Study of the Prevalence of Opiate Use was undertaken by Kelly *et al* (2003) which estimates the figures of 14,452 (Ireland) and 12,456 (Dublin).

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users and resourceful in providing for their own drug use. Research undertaken in Ireland on female drug use has tended to primarily concentrate on pregnant opiate users (O'Connor *et al*, 1988; Keenan *et al*, 1993). Other national research studies that include women commonly treat gender only as a demographic variable and fail to report results separately by sex.

Many contemporary studies demonstrate an increasing proportion of young women using a wide range of drugs. There is clear indication that the problem of female addiction is one of large and growing proportions (Parker and Measham 1994). Although women drug users may represent a substantial "minority" of opiate drug users (Gossop *et al*, 1994), female drug users far exceed men in psychoactive drug use (EMCDDA 2000).² International studies have estimated that women's use of psychotropic drugs exceeds that of their male drug using counterparts. For example, the use of medicines such as benzodiazepines is more common among women than men and the difference increases with age (EMCDDA, 2000).

Overall, in absolute numbers, the numbers of female drug users are still considered low in terms of the total drug using population, despite a decrease of gender differences in illicit drug use among teenagers and young adults (Cassin *et al*, 1998). In Britain, the Home Office figures over the last decade show a consistent figure close to 30% for notified female drug users (Gossop *et al*, 1994). In Ireland, Comiskey's (1998) estimation of the ratio of male to female opiate users in Dublin was estimated to be 3:1. Data collected by the Health Research Board for the Greater Dublin Area illustrates that the numbers of females in treatment is increasing. Twenty two percent of the total treatment contacts in 1995 were female (O'Higgins and Duff, 1997) this increased slightly to 28% in 1996, 32% in 1998 (O'Brien, Moran, Kelleher and Cahill, 2000) and 33% in 1999 (O'Brien, Kelleher and Cahill, 2002). Opiates, in particular heroin, are the primary drug of choice among treated female drug users (O'Brien *et al* 2000). However, it must be noted that these figures represent female drug users who actually present for treatment, and it is generally recognised that women are underrepresented in treatment services (Anglin *et al*, 1987; Gossop *et al*, 1990; Hunter and Judd, 1998). Research undertaken by the Merchants Quay Project on first visit attendees to the Health Promotion Service (n=1337), reported a similar ratio to that of Comiskey (1998), with 23% of all first visit clients being female (Cox and Lawlor 2000). This figure is higher when compared with a similar service in Manchester who reported that 18% of the clients were female (Drug Misuse Database, 1997).

The ability of drug treatment agencies to attract women is questionable and little progress has been made in providing gender-sensitive services (Etorre, 1992). Most drug treatment programmes continue to operate from the perspective of male orientated treatment models which may not only be inappropriate to the needs of female drug users, but which may also further deter them from entering treatment. Women who do enter treatment often do so because they are pregnant, afraid of being imprisoned or are suffering from increasing health problems (NIDA, 1998; Thorn and Green, 1996).

Cox *et al* (1999) reported that first visit female attendees to a Dublin Health Promotion Unit were significantly younger than their male counterparts. Women were on average 22 years (range 15-37 years) at the point of first contact with the Health Promotion Unit, while men were on average 24 years old (range 14-52). Evidence suggests that although there is no significant gender difference in age of first IV drug use, the time interval between first IV drug use and presentation to a drug service is nevertheless shorter for women (Cox *et al* 1999; Gossop *et al*, 1994).

Research has shown that many women who use drugs were introduced to drugs by their male drug using partners (Taylor, 1993). Among heroin users, women are more likely than men to have a partner who uses drugs and are proportionally more likely than their male counterparts to live with a drug using partner (Kane 1993; Gossop *et al*, 1994). In Ireland 28% of female drug users who present for treatment live with another drug user compared with 18% of men (Moran *et al*, 1997). Furthermore, available research also suggests

² Psychotropic drugs are medications prescribed to stabilise or improve mood, mental status or behaviour. Some common types of psychotropic medications include;

- Antidepressants- fluoxetine (Prozac); Sertraline (Zoloft)
- Mood Stabilisers- lithium (e.g. Lithonate)
- Anti-Anxiety- clonazepam (Klonopin)
- Psychostimulants- methylphenidate (Ritalin); dextroamphetamine (Dexedrine)

women who use heroin experience problems that differ substantially from those encountered by male heroin users. They tend to have fewer financial resources, report experiencing more psychiatric and medical problems, and a greater likelihood of having child-care responsibilities (Swift *et al.*, 1996; NIDA, 1998).

2.3 Injecting Risk Behaviour and Gender

There is evidence of a strong association between the frequency of sharing injecting equipment and the transmission of HIV infection (Des Jarlais *et al.*, 1997). Female injecting drug users have significantly higher rates of needle sharing than their male counterparts (Mullen and Barry, 1999). An Australian study, Dwyer *et al.* (1994) found women injecting drug users to be more likely to share injecting equipment because of their reluctance or inability to self-inject. Similarly, an Irish study undertaken by Smyth *et al.* (1995) indicated that females are involved in greater injecting risk behaviour than their male counterparts, due to a significantly higher proportion of females testing positive for Hepatitis C.

Injecting risk behaviour depends on a number of factors such as, the availability of clean equipment and local cultural norms (McKeganey and Barnard, 1992). Injecting risk behaviour is also highly expressive of social ties between people (Burt and Stimson, 1993). The sharing of injecting equipment tends to be largely confined to the immediate social circle of the injector (Bloor 1995) and is highly differentiated by gender (Barnard, 1993). Female drug users are more likely than male injecting drug users to have a sexual partner who is an injecting drug user (McKeganey and Barnard, 1992). Moreover, the greater involvement of women with other drug users can have a considerable impact in terms of injecting risk behaviour (Klee *et al.*, 1990; Cox *et al.*, 1999). Both international (Darke *et al.*, 1998) and national research (Cox and Lawless, 1999) has indicated that female drug users, in particular those with injecting partners, are more likely to report the sharing of injecting equipment and injecting paraphernalia than their male counterparts. For example, Barnard (1993) reported high numbers of female drug users who were frequently injected with used needles and syringes of their partners for personal or social reasons. The problem is that sharing in such circumstances is generally not regarded as risky behaviour by those involved, but rather as a normal part of an intimate relationship. (Burt and Stimson, 1993). Despite the fact that they may share only with their partners, their partners may in turn share with others, which therefore increases the risk of acquiring HIV and/or hepatitis (Mulleady and Sheer, 1989).

It is estimated that injecting heroin users may be at risk of death 20 or 30 times higher than that of the general population of the same age (EMCDDA, 1997). Death attributed to overdose is one of the major contributors to mortality (Drake and Zandor, 1996). International literature suggests that males and females are equally likely to have experienced a non-fatal overdose with males however being over represented in terms of fatalities due to overdose (Gossop *et al.*, 1996; Warner Smith *et al.*, 2000). For example, a study undertaken in Ireland by Ward and Barry (2001) to determine the number of opiate related deaths in 1999, revealed that of the 84 opiate related deaths, seventy eight (92.9%) were male. Overall, very little published Irish research exists despite the fact that during the 1990's the number of drug-related deaths in Ireland had risen substantially, and at a higher rate than any other country in the European Union (EMCDDA, 1999).

2.4 Sexual Risk Behaviour and Gender

Within the general population in Ireland, two out of three women are sexually active, with 31 % of women who are sexually active not currently using any form of family planning (Wiley and Merriman, 1996). Although it is often reported that drug users who take depressants (such as opiates) are less sexually active than the norm, the WHO Collaborative Study group (1993) illustrated that the majority of drug users (75%) are in fact sexually active. International research has shown that levels and patterns of condom use among drug users do not differ substantially from the general heterosexual population (McKeganey *et al.*, 1988; Donoghoe, 1992). Rhodes *et al.* (1994) found that levels of condom use among injecting drug users in London were very low, with two thirds never using condoms with their regular partners, and over a third never using condoms with casual partners. Despite this, levels of condom use were highest among those engaging in prostitution. In a study of 201 opiate dependent women on a methadone maintenance programme, 44% of those who reported being sexually active reported not using any contraceptive method (Morrison *et al.*, 1995). Johnson *et al.*

(1994) study of injecting drug users attending a Dublin needle exchange, noted that while 92% of the research participants were sexually active, a third (33%) never used condoms. Evidence suggests that HIV infection is shifting towards sexual routes, as injecting drug users have curtailed their injecting risk behaviour but continue to have unprotected sex resulting in the sexual transmission of HIV being often overlooked by injecting drug users (Delor, 1997). Similarly O'Gorman's study (1999) found little knowledge of risk awareness or harm reduction strategies with regard to safer sexual practices among injecting drug users.

Prostitution is a means of support for a significant proportion of female drug users and can provide a reliable and steady income, in some cases for up to 60% of women (EMCDDA, 2000). Numerous studies have illustrated that female drug users working in prostitution appear to be younger and have a poorer health status than their non-drug using female counterparts (O'Neill *et al*, 1999; Faugier, 1992; McDonnell *et al*, 1998). Female drug users who work in the sex industry are at increased risk of exposure to HIV and other sexually transmitted infections due to a number of factors including; multiple sexual partners and high risk sexual activity. O'Neill *et al* (1999), in an Irish study undertaken with drug using women working in prostitution ($n=77$), reported that while safer sexual practices were being implemented in their work environment, many were putting themselves at risk in their private relationships. While over 92% ($n=71$) of the women reported always using condoms with their clients only 15% ($n=12$) of them reported always using condoms with their partners in their private lives. Research has highlighted that many street-working women consider condoms symbolic of sex work and therefore inappropriate in their private sexual relationships (McKeganey and Barnard, 1992). Furthermore, a study carried out in Manchester by Faugier *et al* (1992) argued that condom use was less consistent where the woman prostituting was an injecting drug user. Gossop *et al* (1995) study on the relationship between drug use and sexual risk behaviour among female street workers in the south of London, showed that about one quarter of the sample had unprotected vaginal and anal sex with their clients within the previous month. Moreover, few of the sample had used condoms with their regular partner, even though their partner was, in some cases, a drug injector.

2.5 Health Issues of Female Drug Users

Although the life expectancy for women is greater than that for males, they generally appear to suffer poorer health during the course of their lifetime (Payne, 1991). The suggestion is often made that women are more inclined to see themselves as ill or consult a doctor compared to men with similar symptoms (GHS, 1990). Nonetheless, females experience a higher incidence of acute but largely non-fatal illnesses such as, digestive system disorders, and other conditions such as anaemia than their male counterparts, whereas males are more at risk of developing chronic illnesses such as coronary heart disease or other cardiovascular diseases (Don Sabo, 2001). Furthermore, women's symptoms are more likely to be attributed to psychological or "normal female" causes, while those experienced by their male drug using counterparts are more likely to be attributed to physical causes (Gutierrez *et al*, 1994). Social class, poverty and gender are the main predictors of women's health status as poverty based research has clearly illustrated that that women living on low incomes are not only more likely to die younger but are also exposed to a greater risk of illness throughout their lives (Daly, 1989).

Research has also shown that women drug users experience higher levels of medical problems during their drug-using careers, than their male drug using counterparts (Cox *et al*, 1999). Indeed it is often a medical complaint, more specifically, pregnancy, which precipitates a woman's entrance into drug treatment (Taylor, 1993; Lewis *et al*, 1995). Numerous studies have reported that drug-using women are at increased risk of the following medical problems: infections, anaemia, STI's, hepatitis, hypertension, diabetes, urinary tract infections, gynecological problems and dental disease including abscesses (Mondanaro, 1989).

Female drug users may also experience a variety of problems specifically in relation to obstetric outcomes. For example, opioid dependent pregnant women are at increased risk of serious health complaints such as anaemia and high blood pressure in addition to premature labour and stillbirth of their newborns (Finnegan, 1991; Ward *et al*, 1998). Although there is research to suggest that poor pregnancy outcomes may be influenced more by the poor socioeconomic lifestyles of drug users rather than the effects of the drugs themselves, some studies have indicated that heroin use during pregnancy is consistently linked to low birth rate, growth retardation and spontaneous abortion (Hepburn, 1993). There is also evidence that the

engagement of pregnant drug users in methadone treatment can significantly reduce the complications at birth and produce more favourable outcomes (Giles *et al*, 1989).

Injecting drug users in general represent a high-risk group for bloodborne viral infections, including HIV, hepatitis B (HBV) and hepatitis C (HCV). Women who inject drugs are at particular risk of becoming infected with Hepatitis B, Hepatitis C and HIV through sharing injecting equipment with their infected partner (Klee, 1993). Rinear (1996) argues that many of the symptoms of hepatitis B are very similar to those associated with other aspects of drug use indicating that injecting drug users are likely to have positive test results without having had any prior knowledge of their hepatitis status. In recent years there has been increased concern at the reported high levels of hepatitis C among Irish injecting drug users. High levels of HCV have been observed among Irish female injecting drug users. Symth *et al* (1998) illustrates that of the 204 female injecting drug users who tested for hepatitis C within a five-year period (1992-1997) at the National Drug Treatment Centre, 63% were HCV positive.

Female drug injectors are also more likely to be at greater risk of becoming HIV positive than their male drug using counterparts. One New York study revealed that 58 percent of female drug users were HIV positive compared with 40% of male injectors (Des Jarlais *et al*, 1997). Women are more likely than men to contract HIV through an infected sexual partner (Henderson, 1992). Studies have indicated that once infected, female drug users are also more likely to have a shorter survival time from AIDS diagnosis to the period of mortality (Blume *et al*, 1994). In Ireland, Johnson (1994) reported HIV prevalence of 14.8% among a cohort of injecting drug users attending a Dublin needle exchange in 1991. National figures as at the end of June 2001 show that IV drug users represent 41% of the total cases which have tested positive to date, with females accounting for 36% of the new HIV positive cases obtained through intravenous drug use in 2000 (National Disease Surveillance Centre, 2001). The incidence of HIV infection among female drug users is also of increasing concern, as studies have cited that the development of various gynecological complaints related to HIV are frequent. For example, a study by Minkoff *et al* (1999) found that among 262 HIV infected women, 46.9% had at least one incidence of a gynecological condition. Furthermore, the occurrence of human papillomavirus virus (HPV) and cervical dysplasia among HIV infected females can increase the risk of cervical cancer among this population group (Bradbeer, 1987). HIV positive women are also more likely to experience poorer outcomes with cervical cancer in terms of, for example, their responses to therapy and higher rates of recurrence than their HIV negative counterparts (Wilcox, 2001).

HPV infection especially can cause a weakened or suppressed immune system, thus leaving women more vulnerable to other sexually transmitted diseases. Involvement of female drug users in prostitution can place them at increased risk of sexually transmitted infections. (T Neill and O'Connor (1999) reported that less than one third of drug-using women ($n=24$) working in prostitution had been screened for sexually transmitted infections at the time of interview. In nine of the cases, women were diagnosed as having a sexually transmitted infection at screening.

High prevalences of Mycobacterium Tuberculosis (TB) infection have also been observed in drug users (Mathias, 1998). For women, research has indicated that histories of injecting drug use and methadone treatment are regarded as risk factors for the Mycobacterium Tuberculosis infection (Zolopa *et al*, 1994). Although TB infection is often regarded as a clinical manifestation of the HIV infection, evidence has suggested similar rates of TB infection among both HIV seronegative and seropositive drug users (Selwyn *et al*, 1989). Moreover, the probability of developing the disease is substantially higher among HIV-infected individuals. However, it has not been established whether the infection is related to injecting drug use itself or to other TB risk factors. Durante *et al* (1998) illustrated a prevalence rate of 15.7% for the Mycobacterium Tuberculosis infection among 1055 individuals screened at an urban drug treatment facility in USA. This study showed that injecting drug use may be an indication of other risk factors associated with TB, such as malnutrition, close contact or increased susceptibility to respiratory infection rather than being the primary cause of the infection.

Women drug users also suffer from more injecting related complaints than their male counterparts (Cox and Lawless, 2000). Brettell *et al* (1990) categorizes injecting related complaints as those directly resulting from the injecting practice itself (technique specific) or as a result of the complications due to the type of drug used

(substance specific). In terms of technique specific, despite the fact that both sexes report the usual absence from repeated injecting with unclean injecting equipment, females are more likely to complain of difficulty in injecting because of smaller and less visible veins (Cox and Lawless, 2000). Tetanus among heroin users has been reported among females in whom abscesses form due to complications resulting from 'skinpopping'.³ Female injecting drug users also commonly experience infections such as septicaemia, thrombosis, endocarditis and cellulitis (Elion, 1990).

2.6 Use of Health Services

Numerous sociological studies have illustrated that medical services deal with a rather small proportion of symptoms experienced by members of the community with evidence suggesting that many patients with severe medical difficulties do not consult the doctor at all. Kasl and Cobb (1966) developed a conceptual scheme to sociologically examine under what conditions people will and will not visit the doctor. They concluded that in order for an individual to seek medical aid, they must first become aware of a symptom or a problem and then choose to visit the doctor as the most appropriate action. The decision to seek medical help according to Kasl and Cobb, will also depend on an individual's prior experience of medical services and costs and benefits that he/she will receive. Rosenstock (1986) argues that ultimately it is the occurrence of a "trigger" or a "critical incident" which stimulates the individual to seek appropriate medical treatment.

Drug users in general have failed to utilise health services adequately and receive essential health care (Brennan *et al*, 1990), although female drug users tend to report greater medical contact than their male drug user counterparts (Cox and Lawless, 2000). Kleyn *et al* (1993) argue that some drug users are deterred from seeking medical assistance due to the fear of hospitalisation as the fear of withdrawal is greater than the fear of an unchecked illness. A study undertaken by Merchants Quay Ireland on first visit attendees to the Health Promotion Unit illustrated that, despite the fact that nearly half of the clients reported medical contact in the three months prior to presentation at the Unit, levels of medical contact were relatively low among injecting drug users. Forty eight percent of the clients (n=631) reported that they had no contact with medical services (i.e gum clinic, A+E, dentist, G.P, other medical services) while the remaining 52% of clients (n=683) reported some form of medical contact. Female clients were significantly more likely than their male counterparts to report having had some form of medical contact. Seventy percent of female clients reported contact with medical services in the previous three months compared with only 55% of the male clients. More specifically female clients were more likely to report all types of medical contact; Gum Clinic, A&E, dentist, G.P, or other medical services.

On the other hand, Smyth *et al* (1999) a study on the utilisation of health care services among one hundred and five injecting drug users attending a Dublin drug treatment service illustrated surprisingly high levels of reported medical contact. Seventy percent of respondents reported seeing their G.P in the last year with 20% of these visiting in excess of 20 times. While 50% had attended accident and emergency, only 7% reported such visits more than five times. A study undertaken by O'Connor *et al*, (1988) examined the characteristics of drug-using attendees of A&E departments in the Greater Dublin Area to ascertain whether or not they were similar to the profile of those attending a city centre drug treatment service. A&E drug using attendees were older and were also more likely not to be known to the drug treatment service. Hutchinson *et al* (1995) in their comparative analysis of drug using attendees at a Dublin A&E department between 1985 and 1993, revealed that although there was no increase in the numbers of drug using attendees, their drug using profile had changed. Results showed an increase in the use of both benzodiazepines and prescribed opiates as opposed to heroin as the primary drug of choice.

Other research on the nature and extent of medical contact among drug users, has tended to focus on the treatment for opiate dependence or HIV as opposed to contact undertaken exclusively for primary health care. Bury *et al* (1993) interviewed intravenous drug users attending a Dublin HIV Prevention Unit about their use of general practitioner services. Sixty eight percent of clients had visited a GP within the previous year with 48% being registered with a GP under the General Medical Services (GMS). Both methadone treatment

³ Skinpopping refers to an injection between skin and fat layers. Also called "subcutaneous" or "sub-Q" it is injecting drug just beneath the skin.

medical cover under the GMS scheme were important influences on levels of contact with general practitioners. Members of the Scheme were twice as likely to visit a GP as non-members and three times more likely to visit the same doctor for all problems besides methadone treatment. Similarly, Bradley *et al* (1994) carried out research on 150 attendees at a HIV specialist clinic in Ireland on both their attitudes to and their experience of the care received from general practitioners. Eighty one percent had a regular general practitioner, while 64% of them saw their doctor in excess of five times in the previous year. Despite these high levels of attendance, 72% of the respondents reported that they would prefer to attend a hospital clinic if their problems were known to be related to their HIV status.

Desmond *et al* (1993) examined the use of a Dublin inner city A&E department by patients known to be HIV positive. These patients reported that they had attended their GP in addition to the utilisation of the accident and emergency department for their primary health care needs. International research has highlighted that, in general, women with HIV frequent fewer health services than HIV infected men (Hellinger, 1993). A multi-site survey of service use by Hellinger (1993) revealed that women with asymptomatic HIV disease were less likely to receive AZT than asymptomatic HIV positive men, while women with AIDS were also found to be less likely to be hospitalised than men with AIDS. Furthermore, a study by Piette *et al* (1993) found that the prevalence of service need was significantly higher for women with HIV compared with their male counterparts, especially in relation to drug treatment and mental health.

Emphasis is increasingly being placed on the importance of the GP in providing care to drug using clients, not only in the treatment of their drug use but also for their primary health care needs, which may, or may not be as a result of their drug using status. However, international research into GP attitudes has indicated a tendency towards negative attitudes with drug users not likely to be the most favoured of clients (Roche *et al*, 1991). In particular, an Australian survey undertaken among GP's in Sydney, illustrated that opiate users were the least favoured of all patients and a degree of hostility to them was expressed by most GP's (Roche 1991). Drug users themselves have also reported G.P.'s attitudes towards them as being particularly unfavourable (Telfer and Clulow, 1990). Some literature contains evidence that G.P.'s may lack the perceived skill or training to deal with this client group, they may have concerns regarding their personal safety or prejudice against individuals with self-inflicted conditions (Abed and Neira-Munoz 1990; Greenwood 1992). Heller (1994) suggests that the successful management of drug-using individuals within the primary care field is possible if attention is given to other aspects of their lives apart from being "excessively preoccupied" with their drug using status.

2.7 Drug Policy and Gender

The provision of "gender-neutral" treatment has been based on the premise that drug dependence is gender unspecific and that the needs of both male and female drug users are similar. In recent years, however, there has been an increasing awareness of the differing needs and social circumstances of female drug users from those of their male drug using counterparts (Vogt, 2000). In the U.K, the Advisory Council on the Misuse of Drugs (1984) argued that research and policy makers have often assumed that hypotheses and policies drawn up in response to male drug use are equally applicable to women (Dorn and South, 1992). Following on from this, the 1989 ACMD Report recognised that drug services *'should review their policies to ensure that they are receptive to the needs of women'*(1989:140). According to Evason (1993: 216) the fact that women have been largely invisible in the research process has led to policies which seem *"incapable of grappling directly with the problems they are supposed to address"*. Therefore, men and women injectors should be targeted differently in respect of their experiences of a drug injecting lifestyle and also in relation to their risks of HIV transmission (Barnard, 1993). Copelands and HalFs (1992) study suggests that gender specific services have the ability to recruit women who might not otherwise seek treatment for their substance use and also to retain such individuals in treatment.

In 1995 in Beijing, governments from 189 countries at the Fourth UN World Conference on Women adopted an agreement to deliver equality and development for women on twelve main areas, one of these being equal access to health services. Since 1995, the Irish Department of Health and Children have been working to facilitate women's involvement in the delivery of health services. In 1997 the Department of Health, following the *Discussion Paper on Women's Health (1995)* prepared the policy document "A Plan for Women's Health".

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This document argued that a policy for women's health should be based on *"a comprehensive approach to the life experiences of women and the issues which affect their health"* and in particular should target groups of disadvantaged women who may *"experience a concentration of health and other social problems"* (1997:4-5). Moreover, it states that action undertaken must strive not only to reduce those health problems that are unique to women but also those which affect them differently to men. Despite these efforts, the model of health care has greatly changed to take into account women's needs and perspectives. Numerous barriers to both adequate and appropriate health care still exist with restriction of access to, and lack of information on services, marginalising those who are in greatest need of health care.

2.8 Summary and Conclusion

This chapter has provided an overview of the health issues, which impact on women who use drugs. Despite the fact that the numbers of female drug users are considered low in terms of the total drug using population, an increasing proportion of women use a wide range of drugs. In recent years drug treatment services have begun to consider the specific needs and circumstances of female drug users.

Both national and international literature have consistently argued that drug using women are particularly vulnerable in terms of both injecting and sexual risk behaviour. This in turn places them at greater risk of Hep B/C and HIV infections. Their close proximity to other drug users, their increased likelihood of having a regular sexual partner who is an injecting drug user, coupled with a greater reliance on others to help inject themselves creates a high risk environment for female injectors.

High levels of sexual risk behaviour have also been observed. A high proportion of female drug users also engage in prostitution. Although they report high condom use in their work environment, they report placing themselves at risk in their private relationships.

Literature has demonstrated a large proportion of female drug users reporting and presenting with injecting related complaints and high levels of sexually transmitted infections. Although levels of reported contact with medical services are considered relatively high among female drug users (in comparison to those of the general drug using population), there are nevertheless female drug users for whom access to appropriate health care remains difficult. In this regard, various studies on female drug use have advocated a closer examination of their general health needs which extends beyond their reproductive role.

Research Methodology

"We should be free to combine whatever parts of whatever methods we think are promising for our research goals "

(Klein, 1983: 96).

3.1 Researching Women

Although the importance of research in both influencing and directing future social policies cannot be underestimated, numerous research studies are now concentrating on the immediate needs of those examined and the benefits of the research to them. In this regard, research projects generate information on a particular research issue and its findings can then be used to influence future action. Today, research in the social sciences which focuses on changing the situation of women and making them visible is receiving increasing importance. Research *for* women rather than *on* women is a central theme (Daly 2000). Researching the private and emotional experiences of women is now regarded as 'acceptable data' which can highly influence the social and economic inequalities experienced by women (Daly, 2000: 66). In this research, participants are asked to become actively involved in the research project by agreeing to undertake a thorough medical examination. Lee (1993) argues that in researching sensitive issues, such as the above, consideration must be given to the ethical responsibilities involved and we must become more aware of the broader social issues which this type of research raises. Lee (1993) further argues that the sensitivity of the research is largely concerned with the social context in which it occurs as opposed to the actual topic chosen. The importance of undertaking research within an appropriate social setting and developing the research methodology accordingly are equally important. There is no one method that is universally suitable for research on women. A flexible approach is recommended which will allow the nature of the research to determine which method(s) are the most appropriate (Daly 2000). The importance of including women in the research process from the onset is also highly recommended (Lee, 1993).

3.2 Measuring Health

The definition of health employed by the World Health Organisation as ". . . . a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (cited in Albrecht, 1994:13) highlights the importance of including in any measurement of health various social, cultural, subjective and psychological variables that impact on independent living and perceived well-being. Despite the concept of health as being more than an absence of illness, frequently used statistics in the field of health research on the general population tends to concentrate on mortality, life expectancy and a range of morbidity indicators. Measurements in morbidity commonly indicate that various groups of the population may differ, not in their experience of ill health and conditions, but rather in their perception of health and sickness (Payne, 1991).

Numerous sociologists have found that individuals ascribe their own interpretation to their experiences of health and illness (Nettleton, 1995), these interpretations may often be shared by people in the same group as the individual. Therefore in this study, consideration must be given as to whether men and women attach fundamentally different meanings to the concept of health both when assessing their own state of health and their need for medical assistance (Irmgard, 1999).

Individuals are being asked to report their own health status in ways that can be analyzed quantitatively and which will also inform medical practice (Albrecht, 1994). Subjective health assessment is becoming an increasing part of contemporary health services research and clinical practice (Albrecht, 1994). In other words, individuals can provide valuable insights into their own health and well-being which may prove beneficial in determining the overall benefits or harm associated with different medical treatments (Fitzpatrick *et al*, 1999). For example, the health status measure SF-36 (Short Form 36 Health Survey Questionnaire) has been known for its high validity as a standardised health measure (Brazier *et al* 1992). Manderbacka *et al* (1999) argue that "self-reported health is one of the most common indicators of health in survey research and has also been recommended for health monitoring by both the World Health Organisation and the European Union Commission". Furthermore, "qualitative studies of the way respondents themselves perceive self-rated health have reported similar results concerning health behaviours" (1999:1714). However, individual perceptions of personal health, well-being and life satisfaction may often be different to their objective health status. Cornwell (1984) terms this variation as being the 'public' and 'private' accounts of health where individuals only reveal the 'public' account of their health within initial interviews. Measures of morbidity based on self-reports of illness are likely to under-report clinically defined disease (Blaxter, 1990; Evandrou *et al*, 1999). Such measurements are often located within a medical definition of health as being the absence of illness rather than health as a positive state of well being.

The majority of studies in the measurement of health complaints among injecting drug users rely heavily on retrospective self-reported information. However, there are a number of shortcomings associated with the accuracy of self-reported data. Drug users may provide inaccurate information about their past and cumulative experiences as patterns of drug use and sexual practices undergo changes over time (Samuels *et al*, 1998; Bradburn *et al*, 1987). A study undertaken by Kleyn *et al* (1993) on the incidence of sexually transmitted diseases among injecting drug users suggests that the use of self-reported information to measure infection with sexually transmitted diseases or to validate other measures is a questionable practice. Their comparative analysis of survey and serological data revealed discrepancies between results, in particular when respondents said they had no previous history of infection. Kleyn *et al* (1993) argue that to incorporate survey questions with serological testing is of great benefit in providing additional information which can ultimately improve the health of drug injectors. Notwithstanding these concerns, numerous studies have shown that intravenous drug users often provide reasonably accurate information on their drug using practices (McElrath *et al*, 1999) and sexual behaviours (Kleyn *et al*, 1993; Rhodes *et al*, 1996) and are also able to diagnose their injecting related illnesses as accurately as clinicians (Morrison *et al*, 1997). However it is important that subjective health measurement questionnaires are not employed as substitutes for traditional medical tests, but are used instead to complement and inform other medical sources of data (Jenkinson *et al*, 1994). Qualitative methods are also widely used by researchers into the sociology of health (Cleary and Tracy, 1997).

3.3 Combining Methodologies

Quantitative and qualitative methodologies may be perceived as different ways of examining the same research problem (Pawson and Tilley, 1997). The combination of different research methodologies on the study of health problems related to drug use increases both the reliability and validity of the research findings (Jenkinson *et al*, 1994). Quantitative data often relies on the use of the social survey while qualitative research tends to be associated with participant observation or in-depth interviewing. Quantitative data centres on scientific inquiry and allows information to be obtained on individuals known to be representative of a wider population (Bryman, 1988). This research method regards human action as capable of being analysed with reference to the laws of science, i.e., that human action is quantifiable (Ritzer, 1992).

The increasing use of qualitative research as a valid methodology within the social sciences has been widely documented. Qualitative research can also inform the design of quantitative research instruments as well



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3.4 Data Collection

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group at the preliminary stage of a research study can provide an opportunity for the key players in the study to become involved in the research process thereby empowering the participants from the onset. The focus group can allow valuable insights and opinions to be conveyed which can then be used to develop or modify the study accordingly. As described in Chapter One, a focus group was undertaken with a cohort of female attendees to the Contact Centre prior to commencement of the Women's Project. This provided an opportunity to publicise the project, while at the same time identify levels of interest. In addition, issues such as, the limited numbers of females in receipt of medical cards was highlighted early on in the planning stage of the project thus allowing appropriate action to be taken.

3.4.2 Health Information Form

This form provided baseline information on participants' socio-demographic characteristics, drug using patterns, injecting and sexual risk behaviour, in addition to self-reported information on the health status of female injecting drug users.

Participants were firstly asked to provide information on their age, current accommodation type and whether or not they had children and, if so, their ages and child-care arrangements. Participants were also asked if they were currently sharing accommodation with an intravenous drug user so as to ascertain levels of risk behaviour. In terms of drug using patterns, participants were asked at what age they initiated intravenous drug use and the type of drug used. Participants were also asked to state their current primary and secondary drugs, their routes of administration, and whether they were on any prescribed medication. Details of the type of medication, the complaint, and length of time on such medication were also recorded. Clients were also asked to report on their most common injecting site, the extent to which they inject themselves and experienced difficulties in finding an injecting site. In terms of sexual risk behaviour, participants were asked whether or not they were currently sexually active and if so, whether they had more than one sexual partner in the last three months. A question was also included to ascertain whether the participants had a regular sexual partner and whether the partner was an injecting drug user. Participants were also asked to report on their sexual risk behaviour including the main method of contraception employed. Experience of ever having a sexually transmitted infection was also included within this section and if so the date of this diagnosis.

In measuring the subjective health status of female injecting drug users, the use of a symptom checklist, based on the Opiate Treatment Index (OTI) as developed by Darke *et al* (1991) was employed. As the benefits of the OTI instrument are its known reliability and validity, it was decided to employ a similar symptom checklist to measure clients' health and well-being. Many of the illnesses included in the general health question, such as abscesses, septicemia and overdoses are caused by drug use and are indicative of unsafe injecting and drug using techniques. Other items included on the symptom checklist included a range of cardio-respiratory, neurological and gastro-intestinal complaints. A global measure of physical health was also included by employing a global rating scale. This rating scale requires respondents to describe their state of health by answering one question. There is evidence supporting the value of such uncomplicated global ratings in terms of their simplicity and clarity (Ziebland, 1994).

Clients were also asked if they ever had a test for HIV or hepatitis B/C and, if so, date of last test. They were also asked to state whether they currently have hepatitis B, hepatitis C or ever had jaundice and, if so, the medical treatment they are receiving. Jaundice was also included as clients may be unaware of their hepatitis status and experience of jaundice may indicate hepatitis B or C. Clients were also asked whether they ever had a vaccination against hepatitis B.

3.4.3 Semi-Structured Interviews

Semi-structured interviews provide qualitative information from the subjects point of view by exploring ideas and meanings with which they are familiar. Literature has noted that the use of qualitative interviews with women allows them to express their own opinions and interpret the personal meanings they attach to their experiences (May, 1993). In view of the sensitivity of the research project and the perceived personal issues which may emerge, it was considered most suitable to undertake individual semi-structured interviews with a cohort of regular female attendees at the Contact Centre. Some of the areas that were examined within this research context focused on barriers to health care; experience of previous medical health complaints; type of

of medical assistance often sought and general views and opinions of the medical treatment received. A member of the Research Department conducted all interviews in private in the Contact Centre of the Merchant's Quay Project. Consent was obtained and all clients were informed that they could terminate the interview at any point in time.

3.4.4 Medical Assessment Form

This form, as stated earlier, was designed as a research instrument to be completed by the doctor both during and following the medical examination. The information collected on this form included;

- Past Medical History (diabetic, asthmatic, smoker etc)
- <§ Past Surgical History (tonsils etc)
- Gynaecological History (previous pregnancies etc)
- Review of Systems (bowels, any palpitations etc)
- Physical Examination (hands, ear, eyes, throat, cardio-respiratory tests, neurological tests)
- Types of Tests Undertaken (Hep B and C etc).
- Diagnosis/ Findings
- Plan of Action/Referral

Although a review of participants' medical status may, in some cases, have already been covered, through administering the health information form, it was nevertheless essential that the information on past medical/surgical history be collected by the doctor. This information was considered to be of primary relevance for the doctor prior to her undertaking medical examinations, and secondly as a means of collecting additional research data.

3.5 Data Analysis

The quantitative data derived from both the Health Information Form and the Medical Assessment Form were entered into SPSS for Windows (Version 10). All percentages are based on valid responses adjusted for missing data. The qualitative data collected from the interviews with both clients and staff members was firstly transcribed verbatim and then analyzed according to specific themes.

3.6 Summary and Conclusion

This chapter has presented the methodology which was employed to achieve the aims and objectives of the research study. It also highlights the methodological issues involved in understanding and implementing a measurement of health. As outlined in this chapter, there are a number of shortcomings associated with the accuracy of self-reported data. Despite these concerns, a variety of approaches have recommended the use of self-reported data with other standardised measurements of health. Therefore the combination of objective (clinical) and subjective measurements within the Women's Health Project sought to complement and further inform the research findings. Literature has also demonstrated that any measurement of health is fraught with differing definitions and interpretations of 'health'. Studies have illustrated that different groups of the population may differ, not in their experience of ill health but rather in their perception of health and sickness (Payne, 1991; Nettleton, 1995).

Both qualitative and quantitative research techniques were undertaken at various stages of the project. Quantitative methods included the *Health Information Form* and the *Medical Assessment Form*, while focus groups and semi structured interviews with both female clients and staff were undertaken.

Client Profile

4.1 Introduction

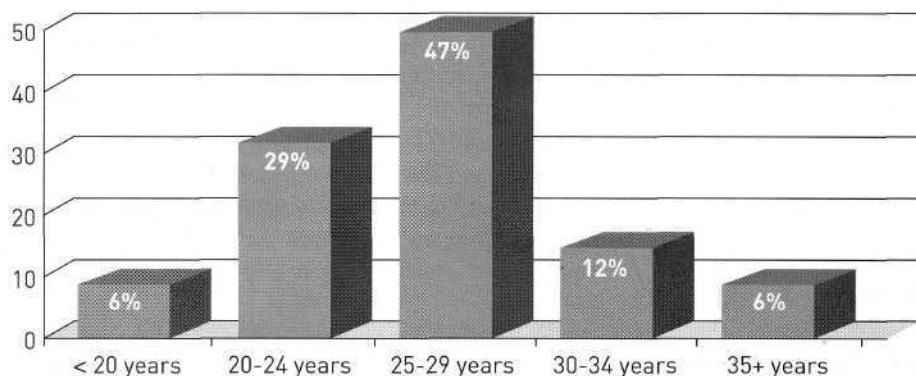
A total of 17 female clients who were regular attendees of the Contact Centre agreed to participate in the research element of the Project which was undertaken prior to the medical intervention on each morning over the eight week period. This figure does not represent all female clients who expressed an interest in the project, as due to the constraints of the study in terms of time and resources not all clients could be accommodated. Nevertheless, every effort was employed to ensure that the majority of clients were facilitated on each morning of the Project. This chapter will examine the profile of those who participated in the study and will explore the needs and social circumstances of a cohort of females who present regularly at this low-threshold service within Dublin's Inner City.

4.2 Socio-Demographic Information

4.2.1 Age

Figure 4.1 demonstrates the age distribution of the participating clients. The age range of clients was 19 to 43 years. Overall, the mean age of clients was 26.7 years. This figure was slightly skewed as it included a forty-three year old who participated in the Project. Nevertheless, 82% ($n=14$) of clients were under the age of thirty years. This mean age was substantially higher than the mean age of 22 years revealed among the total population of first visit female attendees to the Contact Centre over a three year time period (Cox and Lawless, 2000). This can be explained by the fact that all clients who agreed to participate in the Women's Health Project were regular attendees to the Contact Centre and were well established within their drug using behaviour.

FIGURE 4.1 AGE OF CLIENTS



4.2.2 Home Circumstances

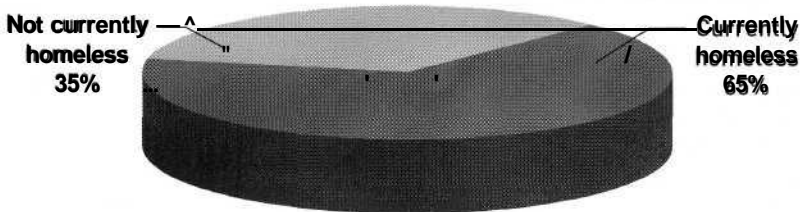
Table 4.1 illustrates the current type of accommodation reported by the participating clients.

TABLE 4.1 ACCOMMODATION TYPE OF CLIENTS

Accommodation	Type <i>n</i>	Total %
B&B	(5)	29
Family Home	(4)	23
Local Authority Flat/House	(2)	12
With Friends	(2)	12
Hostel	(2)	12
Sleeping Rough	(2)	12
Squat	-	-
Private Rented House/Flat/Bed-sit	-	-
Other	-	-

According to the various accommodation types reported above, the majority of clients reported being currently homeless (65%).⁴ Figure 4.2 below illustrates the experience of homelessness among this client group by virtue of their reported accommodation type. Sixty five percent of the female clients ($n=11$) reported being currently homeless in comparison to 35% ($n=6$) who were not.

FIGURE 4.2 HOUSING STATUS OF CLIENTS



Very often the housing circumstances within which drug users find themselves can further compound or place their health at risk. For example, many drug users by virtue of their insecure living arrangements may be more susceptible to homelessness and as such are doubly disadvantaged in that they are at greater risk of a range of both physical and mental health complaints. The following quote highlights the experience of one homeless female client who is also pregnant.

I worry about sleeping on the streets. Many of a time I've been asleep on the street and the police come along and kick us to get up and I'd be terrified I'd get a kick in the stomach. I got pneumonia on the street I was terrified something was going to happen the baby. Being homeless it's very hard to keep you're health in good condition like you only try to keep yourself in good condition.

(27 year-old Female Rough Sleeper)

Furthermore a substantial minority of female clients reported sharing their current accommodation with an injecting drug user. Over a third of female clients ($n=6$, 35%) reported to be in such a high risk social

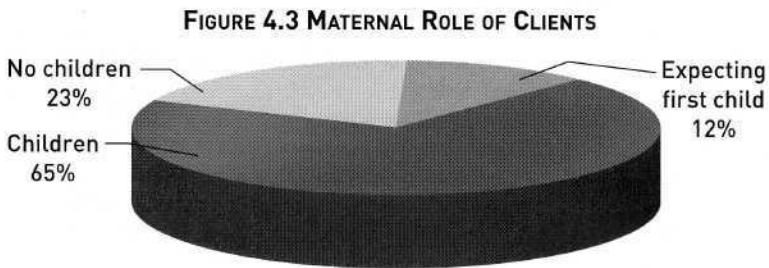
⁴ For the purpose of this research homeless female clients were defined as those who reported living in a hostel, a B&B, a squat, staying with friends or sleeping rough.

Pieces of the Jigsaw

environment in terms of close proximity to other injecting drug users. This figure is similar to that recorded within the treated female drug using population which indicates that women drug users are more likely to be living with a drug using partner. An analysis of the National Drug Treatment Reporting System data for 1998 illustrate that 36% of women reported living with a drug user compared to 22% of men (Moran *et al*, 1999). A high proportion of female clients also reported staying in emergency accommodation such as, hostels and B&B's, in which exclusion policies and sanctions for engagement in drug use are commonly applied. Consequently, some of these clients may actually be unaware of others' drug using status and so this figure could be underestimated within the study.

4.2.3 Childcare Responsibilities

Figure 4.3 illustrates that the majority clients (65%; $n=11$) reported having children, 2 of whom reported being pregnant again at the time of interview. An additional 2 clients were also currently expecting their first child. On average those who reported having children, were 19 years on the birth of their first child with a mean of 2 children per female client (range 1 to 4 children).



The majority of clients reported having child-care responsibility. However, in some cases, female clients felt that due to their present chaotic drug use, their children were better catered for by their extended family or by other arrangements, such as foster care. The following quote from a female client states that her daughter's needs are best met by others until she can manage to rebuild her life.

Me five year old daughter is with me ma I can't look after her at the moment, just until I try to build myself up, up a little bit. I'm barely able to look after myself at the moment.

(24 year old female client)

Another client recalled how she felt when she found out she was pregnant with her son. At that time she states that she was injecting large quantities of heroin and was very fearful of the consequence of her drug use on her ability to care for the child;

Yeah I found out when I was five weeks they test you up the road and I found out there and then, like I knew I was, I got caught straight away I was only out of prison. Although I knew I was, but when she handed me the piece of paper I started roaring crying and I had the drugs worst than ever. Eventhough I wanted the baby I was afraid I wouldn't be able to cope. It was in me head that social workers would take the baby away. Now that I'm off the drugs I can see things a lot clearer.

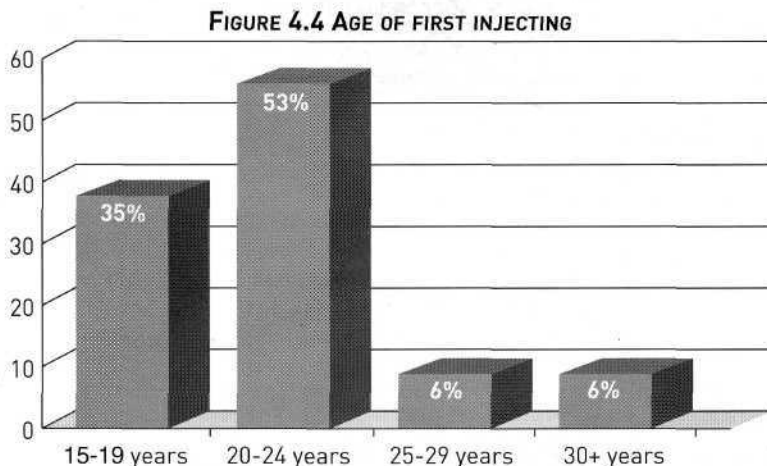
(Female client on methadone maintenance)

4.3 Drug Use

4.3.1 Drug Using History

All participating clients were asked to provide some details regarding their past drug using patterns. They were firstly asked to report on the age of first injecting and the first drug with which they had ever injected. Figure 4.4 demonstrates the age of first reported drug use. It conveys that the majority of female clients had

commenced their injecting drug use prior to 25 years of age (≤ 15 ; 88%), with over a third reporting intravenous drug use before the age of 20 years. The mean age of first injecting was 22 years (range 17-38 years). All clients reported heroin as being the first drug injected.



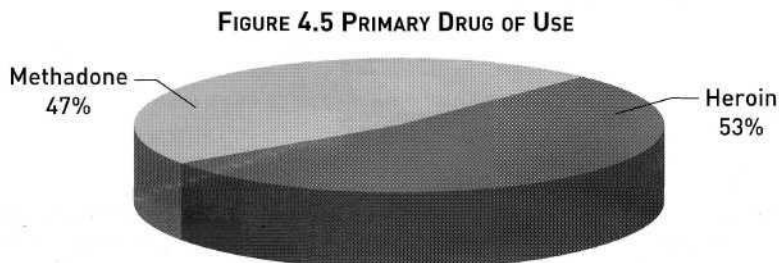
However, as illustrated by *Figure 4.4* above, one client reported having commenced heroin use at the age of thirty-eight. She recalls how the loss of her home and her subsequent accommodation in a hostel had caused her to commence using heroin;

Thirty eight I went on drugs, because I couldn't cope with being homeless [...]. I wouldn't blame anyone, nobody stuck a needle in my arm, it was just the pressure of being homeless, like gettin' married at 20 and having me own home for so long and having your own space, I couldn't relate to the hostel, I just couldn't handle it [...]. I was sitting in the hostel one day and there was this girl sitting down and she looked very relaxed and chilled out, so I said give us a bit of what you're on', I didn't mean heroin, I don't know what I even meant, so then I took it and I was up in heaven somewhere. I didn't care that I was homeless, I didn't care about the cold.

(Homeless Female Client; Presently Rough Sleeping)

4.3.2 Current Drug Use

Clients were asked to detail their drug use over the previous four weeks. *Table 4.5* illustrates that the majority of female clients (≤ 9 ; 53%) reported heroin as their primary drug of choice. The main route of administration of this drug was injecting with only one client reporting skinpopping and another smoked the drug. This was followed by methadone (47%) the majority of whom reported being currently on prescribed methadone.



Pieces of the Jigsaw

Seventy six percent of female clients ($n=13$) were poly drug users reporting a range of secondary drugs including cannabis and cocaine in addition to a variety of tablets such as benzos, valium and dalmane. *Table 4.2* below illustrates the nature of secondary drugs used by the majority of clients.

TABLE U.2 SECONDARY DRUGS USEQ

	Secondary Drug	
	<i>n</i>	%
Heroin	(2)	15
Methadone	(2)	15
Dalmane	(2)	15
Cannabis	(2)	15
Cocaine	(1)	8
Benzodiazepines	(1)	8
Prescribed Valium	(1)	8
Sleeping Tablets	(1)	8
Alcohol	(1)	8

Clients were also asked whether they were presently in receipt of prescribed methadone. *Table 4.3* below illustrates that over three quarters of the clients (76%) were in receipt of prescribed methadone, of whom a substantial proportion had not regarded it as either their primary or secondary drug of choice within the last four weeks. A third of those who were on prescribed methadone were also pregnant at the time of the interview which may also bias the figures.⁵

TABLE U.3 PRESCRIBED METHADONE

Pres. Methadone	Total	
	<i>n</i>	%
Yes	(13)	76
No	(4)	U

Their current drug use was also often complemented by the continuous use of tablets, which sometimes featured neither as a primary or secondary drug of choice. For these clients, the use of tablets was a constant drug using pattern. The female client quote below demonstrates how the use of tablets preceded her first use of heroin;

I was strung out on tablets for years that was even before heroin when I was a kid like.

(Female client; 31 years)

Another client reported how accessibility to, and availability of tablets on the street has impacted on her increased use of tablets. The extent and chaotic nature of her use is evidenced by the fact that she was obliged to sell her prescribed methadone in exchange for tablets.

Everyone around here is takin' them, the tablets just make me mad [...] I wish they weren 't in me face as much because I wouldn 't take them then do ye know what I mean.

⁵ Female drug users who are pregnant are encouraged and facilitated onto a methadone treatment programme as early as possible in their pregnancy. Entry is through a fast track system where their situation is regarded as a priority case for methadone treatment.

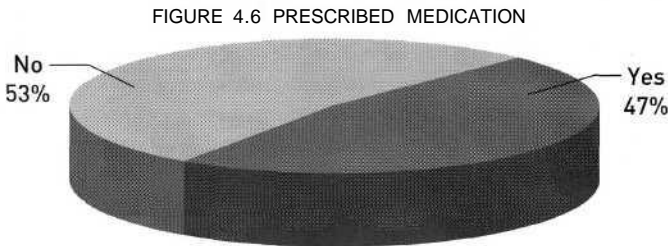
So, what kind of tablets do you usually take?

All sorts, all sorts like ye know anything I can get me hands on, I got week-end takeaways off the clinic and I sold the whole lot to this guy who promised me tablets the week-end gone, and I didn't have anything, so from Friday 2.00 to Monday 2.00 I was going through withdrawals all week-end, crying me eyes out [.....] When I'm on tablets I am very violent, very violent, ye know I used to beat me previous boyfriend for a number of years, he used to be on benzos aswell it changed his whole personality, it's evil.

(Regular female attendee; 28 years)

4.3.3 Prescribed Medication

Considering the high usage of psychotropic drugs by females which has been reported across numerous European countries (EMCDDA, 2000), it was necessary to determine the extent to which participating clients used other prescribed medication, excluding methadone. As Figure 4.6 demonstrates, nearly a half of the clients ($n=8$; 47%) interviewed reported being currently on other prescribed medication. The majority were on some form of anti-depressants or sleeping tablets.



According to the vast majority of clients, prescribed tablets were easily obtained, if required, especially within the Dublin Area. The quote below conveys the ease with which prescribed medication can be made available to, and sourced by a client;

Its so easy to get prescribed valium or whatever, ye just say 'look I've just came from England', ye just go up to the doctor and say ye want tablets and they 'd prescribe them for ye, like I know the doctors, I know most of the doctors that do it.

(Homeless female youth; 19 yrs)

Clients were also asked how long they had been on prescribed medication. Of those currently on prescribed medication, 76% ($n=6$) reported being on it for in excess of three months.

TABLE UM FREQUENCY OF USE OF
PRESCRIBED MEDICATION

Frequency	Total	
	<i>n</i>	%
Less than 1 month	(1)	12
1-2 months	-	-
2-3 months	(1)	12
More than 3 months	(6)	76

Prescribed medication is often sought by the client due to personal difficulties such as being depressed or feeling unable to cope with particular life events. The following quote demonstrates the events which caused

Pieces of the Jigsaw

her to seek prescribed medication, more specifically anti-depressants. It also conveys that having been on medication for more than two years, she is aware of the difficulties in ceasing its use. This is expressed by the effect of missing two days of her anti-depressants;

Well I thought they weren't doin' any good for me but when I miss two or three days I feel very down. So I suppose they are helping me like do ye know what I mean. I found me boyfriend hanging then in 1999 like they put me on them cause my brother hung himself in prison then three weeks later. After that I buried me baby and all. When I don't take them for two or three days everything just gets on top of me, do ye know what I mean, I would find them hard to give up. The doctor says to give it another six or seven months and then see how I am after that.

(24 year old female client)

Similarly the quote below illustrates that although she is not currently on any prescribed medication, she experienced taking anti-depressants for a short period of time within the last year. Unlike the previous client she reported being able to successfully discontinue her use of anti-depressants without immense difficulty. Client 5 notes that the follow-on care which she received from her G.P had a positive impact on her successful outcome;

I was just on anti-depressants when I got pregnant, I was just on them for a good few months so I wouldn't fall back of depression, just like on the doctors advice ye know what I mean. He said that if I ever felt going back into that state again I could just go up and talk to the doctor in the clinic and he would prescribe them again do ye know what I mean. I was only on one a day and I didn't find them addictive at all and I just came straight off them, I just gave them up and it was grand I didn't need them. The doctor was seeing me around two or three weeks after it just to make sure I didn't feel like I was going to fall back into it. Never got any side-effects or anything they just calmed me down and when I came off them every thing just went back to normal.

(27 year-old mother of two)

UM Drug Using Risk Behaviour

4.4.1 Injecting Risk Behaviour

Over a half of the female clients interviewed (53%) reported that they were currently injecting either their primary or secondary drug of choice. Table 4.5 indicates the most common injecting sites reported by clients. The majority of clients (56%) reported injecting in their arm. However a substantial minority reported injecting in particularly problematic sites such as the groin and the neck.

TABLE 4.5 INJECTING SITES

Injecting Site	Total	
	n	%
Arm	(5)	56
Groin	(2)	22
Hands	(1)	11
Neck	(1)	11

All clients were asked whether they injected themselves. Figure 4.7 illustrates that 67% (n=6) reported always injecting themselves, as one female client reported, "no I never let anyone inject me that's one thing I'm told, against it". Only 22% (n=2) reported never injecting themselves.

FIGURE 4.7 INJECTING STATUS OF CLIENTS

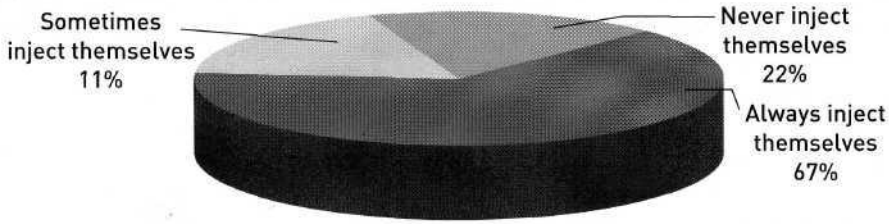


Table 4.6 below shows the proportion of clients who reported experiencing difficulties finding an injecting site. Less than a half of them reported 'never' experiencing problems finding an injecting site with the majority having problems injecting either 'always' or 'sometimes'.

TABLE 4.6 PROBLEMS FINDING INJECTING SITES

Problems- IV Site	Total	
	<i>n</i>	%
Always	(4)	44.5
Sometimes	(1)	11
Never	(4)	44.5

According to one female client, the fact that she commonly experiences difficulties injecting has meant that she rarely injects herself and therefore has to rely on others, in particular her boyfriend, to locate her injecting site;

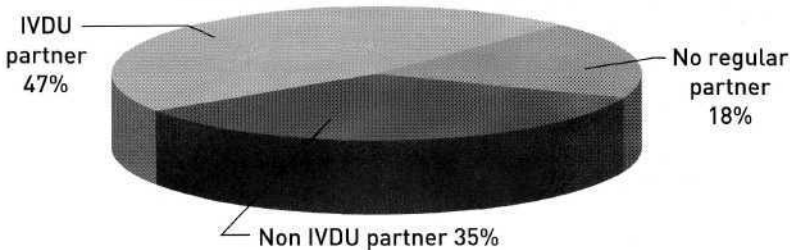
If I was using I'd use in this hand, I've no veins left in that hand, unless I have but I just can't get them. My boyfriend gets the veins for me, I can't get them myself.

(31 year old female client)

4.5 Sexual Risk Behaviour

Information was also collected on the sexual behaviour of female clients. Overall 59% ($n=10$) reported being currently sexually active with only one client reporting in excess of one partner within the last three months⁶ Figure 4.8 below illustrates that 82% of clients ($n=14$) reported having a regular sexual partner and 47% ($w=8$) had a regular partner who was a current drug user.

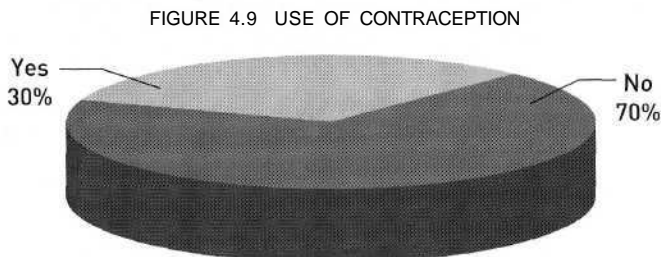
FIGURE 4.8 SEXUAL BEHAVIOUR OF CLIENTS



⁶ This question was included to indicate whether or not clients were currently involved in prostitution, as it was not deemed appropriate to ask the female participants this question directly. However, it is likely that, based on the information above, that clients assumed it to mean 'regular' partners as opposed to 'casual' partners, therefore underestimating the extent of some female clients' sexual behaviour practices.

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Clients were also asked what was their most frequent method of contraception. Of those clients who reported being currently sexually active ($n=10$) only 3 female clients reported currently using a form of contraception. Figure 4.9 shows that 70% of female clients reported not using any form of contraception at the time of interview.

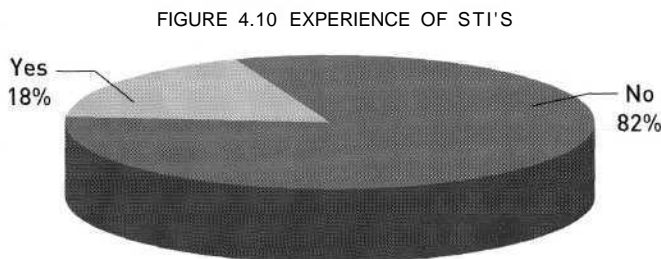


One regular female attendee of the Contact Centre who was currently using contraception, reported that she had commenced using condoms after experiencing a sexually transmitted infection but then ceased to continue with her new regular partner. This substantiates international research which highlights the difficulties introducing condom use into a relationship (McKeganey and Barnard, 1991).

After I caught it [chlamydia] I started using condoms and then I stopped because I'm on the pill and it's a new boyfriend and he doesn't want to use them [condoms].

(19 year-old female)

Figure 4.10 illustrates the experience of sexually transmitted infections (STI) reported by female clients, which conveys that (82%; $n=4$) of clients reported never having had a STI in the past. Of those who did report suffering an infection, only one client reported having experienced a STI in the last year.



This low reporting of sexually transmitted infections may represent only those who have presented for an STI test and are aware of their status. The following client conveys how she accidentally became aware of her positive status;

I had a sexually transmitted disease and pneumonia, infection of the kidneys and a chest infection but I didn't know like, just when I OD [overdosed] and I came around the doctor told me, that's when I found out.

(Regular Female Attendee)

It may be that a large number have never been tested or not recently tested, as this information was recorded. As will be illustrated in the following chapter, the number of requests made, and subsequent tests undertaken among the female clients for sexually transmitted infections was extremely high, indicating a strong demand for these tests.

4.6 Summary and Conclusion

This chapter has presented an overview of the profile of female clients who agreed to participate in the Women's Health Project. Despite this profile, it is not known to what extent these clients are representative of other female regular attendees of both the Contact Centre and other similar drug services. The high levels of clients in receipt of prescribed methadone is surprising, even taking into account the proportion of women who are pregnant. Despite this finding, their drug using practices can be regarded as no less chaotic given their sustained use of psychotropic drugs and regular use of other illicit drugs (in particular heroin). These polydrug using patterns among drug users reflect international literature which highlights that the problem of female drug use is one of large and growing proportions.

Nearly two thirds of female clients reported being currently 'out of home'. Both national (Cox and Lawless, 1999) and international studies (Flemen, 1997) have illustrated high levels of homelessness among the drug-using population. Moreover, studies have continuously shown that homeless individuals are at increased risk of, and experience a greater range of health problems than the general population (Pleace and Quilgars, 1996). Among the drug using population, unstable housing conditions can lead to increased risk behaviour. The lack of predictable and safe places to inject, enhanced dependency on peers and the chaotic and depressing lifestyle all contribute towards creating a high risk social environment for the drug user. Homelessness among drug using women presents an additional health risk for the women, which is beyond the effects of drug use itself (Robertson, 1991). For example, exclusion policies based on a woman's drug using status can prevent them from accessing emergency shelters or transitional housing which are often settings in which access to appropriate health care, welfare advocacy and other essential services are promoted and initiated (Robertson, 1991). Furthermore, homeless drug using pregnant women by virtue of their limited contact with services and 'hard to reach' profile tend to delay prenatal care, thereby potentially risking the health of the woman and the child.

Self-Reported Health Complaints and Contact with Medical Services

5.1 Subjective Health Assessment

This information is intended to examine clients' subjective health and well-being and to complement the objective measure of health assessment undertaken by the medical personnel. Subjective health assessment asks people to report on their own health, illnesses and functional status. In measuring the subjective experience of health, it is assumed that individuals often experience specific complaints that cannot be measured by objective tests alone (Albrecht, 1994). Similarly, according to Jenkinson (1994) it is also possible for an individual to have a serious medical complaint without having any subjective awareness of their illness. Consequently, the employment of various measurements of health assessment cannot be underestimated and so it was deemed appropriate to include the following self-reported health information on female clients.

5.1.1 General Health

As outlined in Chapter Three, the use of a symptom checklist, based on the Opiate Treatment Index (OTI) as developed by Darke *et al* (1991) was employed. This symptom checklist included a range of health complaints such as physical, neurological, cardio-respiratory and musculo-skeletal complaints. Female clients were asked to report on their experience of these complaints from three different time periods; in the last week, month, and 3 months. Overall a large proportion of clients ($n=16$; 94%) reported experiencing a health complaint within the week prior to their presentation at the Women's Health Project. Furthermore, all of the participants also reported having at least one of the cited medical complaints during the last three months. More specifically, a large number of clients reported experiencing disruptive sleep patterns especially for lengthy periods of time. The following quotes highlight the extent to which female clients regard sleep problems and constant tiredness as a familiar health complaint;

I always fall asleep, sleep a lot, I was often accused of being stoned out of me face. If somebody asked me if I was using I'd say yeah I was using, but I'd be genuinely tired, I nod off and waken it was like a heavy goofing I'd be in, it happens to me constantly. It just comes over ye.

(27 year old female)

I'm very tired all the time, sixteen hours a day that's not an exaggeration, if me boyfriend was here he'd tell you the same thing as soon as I get up out of bed I just want to get back in, I'm just tired and tired all the time. But I do have to go to work, and I'm late for work sometimes or I miss some days, even when I go to work I'm sittin' down, tired all the time.

(Female client, mother of two)

TABLE 5.1 SELF-REPORTED HEALTH COMPLAINTS

Complaint	Week		Month		3 Months	
	n	%	n	%	n	%
Sleep Problems	(14)	82	(15)	88	(10)	59
Constant Fatigue	(10)	59	(11)	65	(6)	35
Weight Change	(8)	47	(8)	47	(7)	41
Shortness of Breath	(7)	41	(7)	41	(8)	47
Poor Appetite	(6)	35	(6)	35	(7)	41
Nausea/Vomiting	(8)	47	(6)	35	(5)	29
Stomach Pain	(7)	41	(6)	35	(5)	29
Back Pain	(6)	35	(6)	35	(5)	29
Headaches	(5)	29	(7)	41	(5)	29
Dizziness/Faintness	(3)	18	(2)	12	(3)	18
Skin Wounds/Infection	(4)	23	(4)	23	(5)	29
Dental Problems	(2)	12	(1)	6	(1)	6
Eye/Ear	(1)	6	(1)	6	(1)	6
Foot Problems	(1)	6	(1)	6	(1)	6

Table 5.1 above illustrates the extent to which clients reported having experienced a range of physical health complaints within the last week, month, and 3 months. As already stated a large proportion of clients reported sleep problems ($n=10$; 59%) and constant fatigue ($n=6$; 35%) as a primary concern over the last three months. Other physical complaints such as, nausea/vomiting, stomach pain, poor appetite and shortness of breath were also reported by a large majority of clients.

5.1.2 Psychological Health

Numerous reports have cited the high incidence of mental health such as anxiety and depression among drug users (Hall and Farrell, 1997). Clinical studies have indicated that approximately 50% of opiate dependent individuals report life-time depression, and female drug users, in particular, have been shown to be more likely to report depression (Marsden *et al*, 2000). Therefore all participating clients were asked to provide self-reported information on a number of psychological complaints. In this study, reported mental health complaints were extremely high with 94% ($n=16$) of the female clients reporting having experienced one of the mentioned psychological health complaints within the three months prior to interview. Table 5.2 below illustrates that over three-quarters of respondents reported suffering from depression ($n=14$; 82%). Fifty six percent reported feeling isolated with over half of the respondents also feeling unable to cope.⁷

⁷ These figures are based on a subjective evaluation of their psychological health. The use of a number of objective indicators of psychiatric health, such as, a psychiatric assessment or admittance to a psychiatric hospital, failed to be included within the research instruments unless mentioned by the clients themselves with reference to previous experience of hospitalisation.

TABLE 5.2 SELF-REPORTED PSYCHOLOGICAL COMPLAINTS

Psychological Complaint	Yes	
	n	%
Depression	(14)	82
Anxiety	(11)	65
Feeling Unable to Cope	(10)	59
Feeling Isolated	(9)	56

5.1.3 Perceived Health Status

All clients were asked a number of questions regarding their perceived health status. By allowing individuals to evaluate their own health status, it can contribute towards reducing the complexities involved in assessing health. Individuals may often be aware of a range of health complaints yet still regard their overall health as good (Jenkinson *et al*, 1994). Clients were firstly asked to assess their physical health status on a five-point scale ranging from 'very bad' to 'very good'. *Table 5.3* illustrates that nearly half of clients (47%) reported that their physical health was 'O.K.', while 41% reported that their health as 'bad' or 'very bad'.

TABLE 5.3 PERCEIVED PHYSICAL HEALTH STATUS

Rate Health	Total	
	n	%
Very Bad	(3)	18
Bad	(4)	23
O.K	(8)	47
Good	(2)	12
Very Good	-	-

Clients were also asked to rate their current health status in comparison to that of a year ago on a similar five-point scale. As demonstrated in *Table 5.4* below, a substantial minority of them regarded their general health as being 'much better'.

TABLE 5.4 PERCEIVED CHANGES IN HEALTH STATUS

Rate Health	Total	
	n	%
Much Better	(7)	41
Somewhat Better	(1)	6
About the Same	(3)	18
Somewhat Worse	(2)	12
Much Worse	(4)	23

5.2 Drug Related Problems - Technique Specific

Clients were asked to report on the level of injecting-related complaints and more specifically their experience of such complaints within the last week, month, and 3 months. Of those injecting, 67% (n=6) reported having had experienced at least one of the injecting related complaints listed below. In addition, over half the clients reported experiencing an injecting-related complaint within the last week/month with 56% reporting a complaint within the previous three months.

TABLE 5.5 SELF-REPORTED INJECTING - RELATED COMPLAINTS

Injecting Complaints	Week		Month		3 Months	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Overdoses	-	-	-	-	-	-
Abscesses	4	36	3	27	3	27
Dirty Hit	-	-	-	-	1	9
Scarring/Bruising	6	54	6	54	5	45
Diff. Finding Veins	5	45	6	54	5	45

Table 5.5 above illustrates that both bruising of the injecting site and difficulty finding veins were the most reported injecting related complaints. Moreover, these complaints were reported to be both continuous and consistent within their drug using practices. The following quote highlights these difficulties which are commonly experienced by female injectors which are indicative of unsafe injecting and drug using techniques;

First I started using in me hand but I've no veins left, so I started using in me ankles, oh my god the pain, I actually blew me ankle and the pain of it, it was throbbing.....I even let someone go into me neck once, you don't care you need it so badly you 'd go anywhere.

(Female Street Worker)

The lack of immediate care and attention for injecting-related complaints such as abscesses meant that they often developed into greater problems with further health implications for the female client.

The first very bad abscesses I had was two years ago I nearly lost my hand, the pressure, my hand blew up so big, it was like another hand on top of a hand, me fingers had all gone black.

INTERVIEWER: IS that where you injected in your hand?

Right there. I missed a hit that's what caused the abscess— I was after leaving it for a while I thought it would just burst itself and I cleaned it and all but it didn't I had to go to hospital.

INTERVIEWER: Did you go to the doctor first or did you go straight to the hospital?

I went straight to X [a hospital] it was in the night time actually and I couldn't stick the pain I had the hand on the heater to stop the pain, I thought it was stopping the pain I was getting some kind of relief. Believe me I never used as much heroin in all my life as when I did when I had the abscess to kill the pain..... it was that bad, it was ugly, I was even embarrassed to show it, it was ugly. The worst thing I had ever witnessed in my life.

(26 year old female client)

The next quote by a female client shows the seriousness of such complaints when left unattended. It refers to a conversation which occurred between a nurse and a female client at a methadone clinic.

I gave me first urine last Monday in X for the methadone... when I went to get the second urine they said I was a priority case in a sense. She said [the nurse] it's surprising that you have your legs, that they haven't fallen off ye yet with the septicaemia being so bad from skinpopping.

INTERVIEWER: Did you know that your septicaemia was so bad?

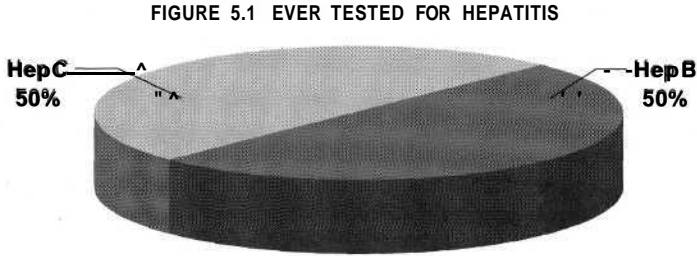
I knew they were bad but I often come down here [Merchants Quay], she [the hospital nurse] offered to dress me legs but it would have been a bit more embarrassing with a new nurse, but I did, I pulled down my trousers and showed her and she said 'oh my god amputation is in line here', so that's after frightening me.

(Regular Female Client)

5.3 Blood Borne Infections

5.3.1 Hepatitis B/C

All clients were asked to state whether or not they had ever been tested for Hepatitis B or C. *Figure 5.1* indicates that all clients with the exception of one reported having previously being tested for either hepatitis B or C, or both, in the past.



Clients were also asked to report on the length of time since their last test. *Table 5.6* illustrates that only 25% (n=4) of clients reported not having had a hepatitis test within the last 2 years. The fact that a large proportion of clients are pregnant or in receipt of prescribed methadone within the vicinity, means that they can avail of hepatitis screening at any time within their clinic. This may account for the high level of reported hepatitis testing among this client group.

TABLE 5.6 LENGTH OF TIME SINCE LAST HEPATITIS TESTING

Length of Time	Hep B		Hep C	
	n	%	n	%
Less than 12 months	(10)	62.5	(10)	62.5
1-2 years	(2)	12.5	(2)	12.5
2-3 years	(2)	12.5	(2)	12.5
More than 3 years	(2)	12.5	(2)	12.5

Table 5.7 illustrates whether or not clients reported ever having had either hepatitis or jaundice in the past. It also conveys the extent to which clients were aware of these infections prior to undertaking the medical intervention. Sixty five percent reported being hepatitis C positive at the time of the interview, all of whom had received an official diagnosis of their status (n=1). Only a minority reported currently having had hepatitis B (18%) or jaundice (12%).

TABLE 5.7 HEPATITIS (B AND C) AND JAUNDICE

Complaint	Jaundice		Hepatitis B		Hepatitis C	
	n	%	n	%	n	%
Yes	(2)	12	(3)	18	(11)	(65)
No	(15)	88	(U)	82	(6)	(35)
Total	17	100	17	100	17	100

Clients reported having acquired the hepatitis infection through a range of both injecting and sexual risk behaviours. The client below shows how the difficulties of financing her chaotic heroin use had caused her to engage in streetwork which resulted in the transmission of hepatitis C;

INTERVIEWER: DO you know how you got hepatitis?

When I started injecting heroin, me habit went up so I ended up starting to work on the street, that's how I got it, I do work on the street to collect money for the gear and the drink and whatever.

(Female Streetworker)

It is often argued that the close proximity of female drug users to other injecting drug users (especially an injecting regular sexual partner), can place them at greater risk. The following quote however highlights the protective nature of such a relationship. She states that as a result of the imprisonment of her partner, she began sharing injecting equipment with others and thus acquired hepatitis;

Yeah I have the hepatitis C I got it from sharing. Me boyfriend was locked up at the time that I got it so I know even who I got that off.

(27 year-old female)

Reports from clients indicated that very often both the diagnosis and disclosure of hepatitis occurred in an ad hoc manner. Clients' contact with external agencies such as drug services, probation and welfare services meant that these services were sometimes involved in, or initiated, the required type of medical contact for the client. The following statements convey the circumstances under which numerous female clients reported hearing of their hepatitis health complaint;

INTERVIEWER: When were you diagnosed with hepatitis C?

I was in X [a prison] at the time and you know the way for the medics you have to go and get tested so they know if you have anything in case you bleed, they always wear surgical gloves anyway no matter what, they have to know whether you have hepatitis or HIV.

(28 year-old Female Client)

I only found out I had hepatitis when I found out I was pregnant they test you for the virus and thank god I was negative but I had the hepatitis. I still judge that as a disease because if you ill-treat it, it can go bad.

(Regular Female Client)

Clients also reported a lack of sensitivity and understanding in the manner in which they were informed of their hepatitis status. Moreover, they were given limited information regarding the follow-on care and treatment of the infection.

INTERVIEWER: In terms of hepatitis B and C, who told you, your doctor or the hospital?

X[a hospital] told me_They were and weren 't nice about it. If I had a problem or questions to ask, some of the nurses could be abrupt or not answer.

(19 year-old Female Client)

Like when I went up there and found out I had the hepatitis the doctor turned around and very cheeky said if ye hadn 't have done that [mimed the injecting routine] ye wouldn 't have got it, he was very smart about it. That's why I don't like telling doctors about things.

(21 year-old Regular Client)

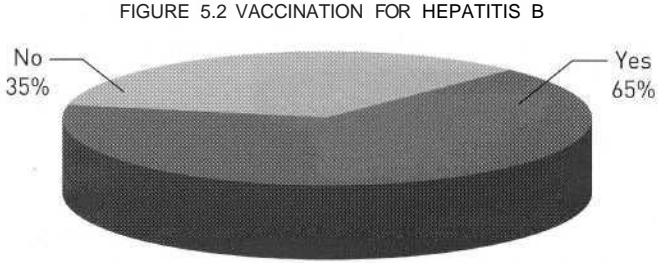
I was just diagnosed with Hep C about a month ago, what happened was I went into me doctor got the test done and then he gave me the results back of the Hep . Now a lot of people were sayin' to me you don't have to worry about this, that and the other, but I have no information, I didn 't get no information off the doctor at the time, ye know, basically what he turned around and said to me was "it 's the best one ye could get, if ye were to get any, this is

Pieces of the Jigsaw

the best one ye could get because it's treated better", ye know, now that's the only information I got, he didn 't ask if I wanted counselling or anything, he didn 't give me any leaflets or anything like that.

(Homeless Female; 24 years)

In view of the risk of hepatitis B infection to injecting drug users, clients were asked whether they had received a vaccination against hepatitis B. *Figure 5.2* illustrates that 65% (n=1) reported having received the hepatitis B vaccination.



5.3.2 HIV

Clients were also asked about whether or not they had ever been tested for HIV and if so, the date of their last test. *Figure 5.3* demonstrates that 82% of the participants had previously been tested, with the majority having undertaken the test within the last 12 months as illustrated in *Table 5.8* below.

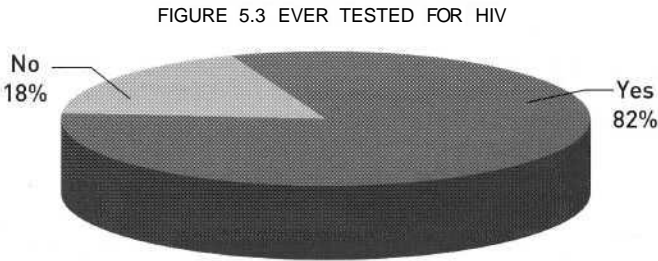


TABLE 5.8 LENGTH OF TIME SINCE LAST HIV TEST

HIVTesting	Yes		No	
	n	%	n	%
Less than 12 months	(9)	65	(5)	35
1-2 years	(2)	U	(12)	86
2-3 years	(2)	U	(12)	86
More than 3 years	(1)	7	(13)	93

Clients were not asked to state their HIV status. Some clients did, however, volunteer this information during the interview, although it was not recorded. In the majority of these cases, clients referred to their known status on their last date of testing and commonly commented on not being aware of their current status. The following client recognises that she is not ready to be tested again as she has now stabilised herself on methadone and is aware of the consequences of being tested;

/ didn't have a test for HIV since last year. I don't know what way I am this year. I'm not ready to have another test. The time I gave the last test I was on gear and ye say ' what the fuck '. Whereas now I'm more aware and you give it more thought. When you come off the drugs you start going back to the old person you were again before you were ever on drugs.

(28 year-old female client)

5.4 Medical Contact

5.4.1 Access to Medical Services

Clients were asked to state whether or not they had ever experienced any difficulties accessing medical treatment. Twenty nine percent ($n=5$) reported that they had experienced difficulties in accessing medical treatment at some time in the past. The majority cited difficulties such as, the strict appointment times of G.P's sneagsaes, and previous negative attitudes displayed by some medical service providers.

Clients were then asked whether they were currently registered with a general practitioner and if so, the extent to which the G.P's practice was geographically accessible for them. Overall, 82% were registered with a G.P. Table 5.9 illustrates that just over a half of the clients, registered with a G.P, reported that the practice was in their locality and easily accessible to them. However, a substantial proportion of clients also reported that their G.P's practice was not geographically accessible. At times this resulted in their attendance at A&E departments or leaving their complaint unattended.

TABLE 5.9 REGISTERED WITH A G.P ANYWHERE

Registered with a G.P	Yes	
	<i>n</i>	%
Yes, in this area	(8)	47
Yes, not geographically accessible	(6)	35
No	(3)	18
Total	17	100

Table 5.10 illustrates the extent to which clients were in receipt of a medical card. It conveys that 35% of clients reported having a current medical card, with a further 35% in the process of applying for one. As outlined in Chapter One of the report, prior to the implementation of the Women's Health Project, the staff of the Contact Centre were actively involved in highlighting the importance of acquiring a medical card. Drug workers at the Contact Centre were involved in distributing medical card application forms and providing assistance to female clients in completing the forms. These interventions, no doubt, positively influenced the high numbers of female clients who reported either currently having, or being in the process of applying for a medical card.

TABLE 5.10 MEDICAL CARD

Medical Card	Yes	
	<i>n</i>	%
Yes, current	(6)	35
Yes, out of date	(4)	24
Process of applying	(6)	35
Other*	(1)	6

*Client was covered under her family's private health insurance

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A quarter of the female clients did report that their medical card was out of date and that it was difficult to obtain a new one. In particular, clients who were currently homeless reported that the absence of a permanent address and the tendency for homeless people to move and be moved between areas often made a medical card very difficult to obtain, as the following client conveys;

INTERVIEWER: IS it hard for you to obtain a medical card?

No it's not that. It's just that I don't have any address. Everything revolves around having an address. Nobody wants to have a drug addict living in their house. Nobody wants to rent out a flat to a drug user.

(Female Emergency Hostel Dweller)

Another client reported that it was an arduous task. She often had meant to process her form once it was completed but then tended to put it aside and forget about it.

INTERVIEWER: Why do you not have a medical card?

You get lazy, you say that okay I'll fill in the medical card form tomorrow, then tomorrow comes, you 'II say you 'II do it later on and you don't do it.

(Regular Female Client)

5.4.2 Contact with Medical Services

All clients were asked to report on their contact with various medical service providers within the three-month period prior to interview. Seventy seven percent ($n=13$) of clients reported having had at least one contact with a medical service provider within this time period. As illustrated in Table 5.11, the level of contact reported with both the general practitioner and the pharmacist within the last three months was high, with 53% and 47% of clients reporting such contact respectively. However, it is argued that the nature of these interventions was primarily due to their drug using patterns as opposed to being a health-related complaint. In other words, the majority of clients reported this contact in order to obtain their prescribed medication, i.e., methadone or anti-depressants.

TABLE 5.11 CONTACT WITH MEDICAL SERVICES
WITHIN LAST 3 MONTHS

Service	Yes	
	n	%
General Practitioner	(9)	53
Pharmacist	(8)	47
Accident & Emergency	(5) ⁸	29
Dentist	(3)	18
Gum Clinic	-	-

Apart from obtaining prescribed medication, clients (with the exception of those who were pregnant)⁸ reported poor contact with medical service providers in terms of maintaining their overall health and well-being, as the following client conveys;

Drug addicts don't go to the doctor because they know they 've gone that far, that no matter what help they get it's not going to change them, it's not going to change their health.

(29 Year -Old Regular Female Client)

⁸ These clients reported routine contact with various maternity hospitals and were all receiving pre-natal care at the time of the interview.

One female client also reported being extremely concerned about her physical appearance as a result of her drug use and often failed to seek appropriate treatment because she was often embarrassed to present with certain complaints.

Well to be honest with you I don't even have a doctor now before I went on drugs I had a doctor, well you know both physically and personally you don't go.

(29 Year-Old Rough Sleeper)

5.4.3 Experience of Medical Services

Overall the majority of clients reported a lack of understanding and sensitivity among medical service providers in responding to their specific needs and circumstances. These attitudes influenced the treatment they received. The extent to which their drug using status impact on the care and attention they received in the post is clear from the following quotes;

In the hospital they have no time for me, or for drug addicts at all. You can see even when she was taking blood from me wrists she was actually hurting me while she was doin' it and I had to ask the nurse to stop. She hadn't a clue, she wasn't even looking where she was sticking it. She went three times into me wrists to get one vein to get some blood out of me and in the end she just went off to get somebody else, she said 'them veins have seen their day' and she started laughing.

(Regular Female Client)

When you 're brought in you 're treated okay and if they see any track marks or if they know by looking at you, they can tell by looking at you if you 're a drug addict, their whole attitude changes towards you.

**

(Female Street Worker)

If they were having to clean any part [of the body] or take some blood or anything they were real afraid to touch you in case they'd catch something, like they had gloves on them and they were being protected either way.

(25 Year-Old Mother of Two)

On the other hand, some female clients reported specific instances of favorable and sympathetic attitudes among medical service providers, as the following quotes illustrate;

The doctor said because it was me first time there [in the hospital] he said he would take good care of me and he did, he treated me with respect eventhough I was a drug user, not that I shouldn't be, but once they hear you use drugs, gloves and everything come out.

(Regular female client)

INTERVIEWER: SO do you go to your G.P for all medical problems?

Yeah, I go to Doctor X up at the hospital at the back. He has a great interest in the drug problem aswell and anything that goes with it, he's very serious when it comes to your health aswell.

(27 year-old female client)

5.4.4 Medical Sources of References

Finally, clients were asked to state the primary means through which they usually access advice and information on medical health complaints. The first question related to their most frequent source of consultation, in terms of medical service providers. *Table 5.12* below illustrates that over a quarter of clients reported not seeking any initial source of medical assistance if they had a health complaint. They would

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usually take care of the complaint themselves prior to presenting at a medical service provider as the following quote conveys;

I'd look after meself and if it got worse I'd go to the A&E or whatever. I'd leave it until it got really bad and then I'd go.

(Regular Female Attendee)

However a further 29% of clients did report that they would usually attend their general practitioner as their initial means of consultation. This consultation was highly influenced by the nature of the medical complaint and the degree to which the client felt comfortable with her general practitioner as the following quote illustrates;

Like I wouldn't go in and ask him to do a smear test or I wouldn't ask him to do a breast check or anything not by a man. I would tell him what way I was thinking, but about certain things I prefer to talk to a woman doctor, I usually go to him with the kids and he 'd [doctor] would check them from head to toe.

(Female Client; Mother of 3)

TABLE 5.12 SOURCE OF CONSULTATION ON HEALTH ISSUES

Service	Yes	
	n	%
Self-Care	(5)	29
General Practitioner	(5)	29
Drugs Workers	(4)	24
Accident and Emergency	(3)	18

Table 5.13 presents the usual means by which clients access information on health related issues. Only a small proportion of female clients reported having nowhere to obtain such information. The majority of clients reported receiving information within the setting of the drug clinic, either from the drug workers themselves or from leaflets/posters which are commonly publicized. One client stated that she usually obtains her information "from the walls of the drug clinic".

TABLE 5.13 SOURCE OF INFORMATION ON HEALTH ISSUES

Service	Yes	
	n	%
Drug Clinic	(4)	23.5
Hospital	(3)	17.5
Family/Friends	(3)	17.5
Books/Magazines	(3)	17.5
Nowhere	(2)	12
Pharmacy	(1)	6
Public Health Nurse	[1]	6

Other sources included information from books/magazines, A&E departments, friends and family and their local pharmacist.

Like I'd get some advice from the chemist, like if painkillers have codine, me urines it'd be dirty so I just ask the chemist for certain information especially like that.

(Female Client; 30 years)

/ usually read about it, or else I might ask the nurse in the clinic or the counsellor.

(31 year old Female Client)

5.5 Summary and Conclusion

This chapter has provided clients' self-reported information on a range of health complaints. Firstly, there is a high incidence of self-reported psychiatric complaints among the female clients who participated in the Women's Health Project. Findings illustrate that 94% ($n=16$) of female clients experienced at least one of the cited psychological complaints within the three months prior to interview. More specifically, 82% ($n=14$) of clients reported depression, 65% ($n=11$) anxiety, 59% ($n=10$) of clients felt unable to cope and 56% ($n=9$) reported isolation. These findings support international literature which highlights that drug users represent a high risk group in terms of mental health problems, in particular depression (Kokkevi and Stefanis, 1993). Furthermore, the rate of co-occurring substance use and mental health problems is relatively high among the female drug using population (NIDA, 1998). The fact that over a half of the women (65%) also reported being homeless at the time of interview is consistent with national studies which have shown that depression is the most common mental health complaint among homeless women. Over 70% of all respondents reported depressive illness in one Irish study (Smith *et al*, 2001). Compared to results obtained from a similar study among homeless men (Feeney, 2000), homeless women were proportionally more likely to report all psychological health complaints (Smith *et al*, 2001).

Injecting-related complaints were also reported by over half of the female clients (67%; $n=6$) at the time of the interview with 56% reporting a complaint for the previous three months. Scarring of the injecting site, difficulty finding veins and abscesses were consistent complaints during the previous week, month and 3 months prior to interview. Such difficulties can place the drug user at increased risk as it can produce a reliance on others to inject her and she may be more likely to share injecting equipment (Mullen and Barry, 1999).

The level of access to, and experience of contact with medical service providers was also dealt with within this chapter. Although levels of medical contact were high with both the general practitioner and the pharmacist, this contact was highly influenced by whether or not clients were in receipt of prescribed methadone. Overall, clients reported negative attitudes and a lack of understanding and sensitivity by different services in response to their health complaints.

6

The Medical Intervention

This chapter will examine the implementation of the Women's Health Project over the eight-week period and will detail more specifically the nature and extent of the medical interventions undertaken. As an investigative research project, these medical interventions sought to explore the current health status among a cohort of female drug users by undertaking a detailed clinical assessment of their health in addition to a range of laboratory tests. The data derived from this investigation provides supplementary information to the subjective accounts of their health status which are detailed in the previous chapter.

6.1 Level of Participation

As outlined in Chapter One of the Report, the Women's Health Project operated one morning a week within the Contact Centre of Merchants Quay Ireland. As a low threshold service, this environment was conducive to attracting a large number of female participants, who by virtue of their presentation to the service, would be generally regarded as chaotic in their drug using patterns and behaviour. Of the 17 female clients who initially participated in the research element of the study, over 88% (≤ 15) of these clients also agreed to undertake the clinical assessment which was carried out by the medical team. *Table 6.1* below illustrates the frequency of visits by the participating female clients. In total, 33 interventions were made which includes *li* follow-up interventions undertaken with 11 clients within the eight-week period.

TABLE 6.1 FREQUENCY OF ATTENDANCE BY CLIENTS

	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8
1	■							
2	■							
3		■						
4		■						
5		■						
6		■						
7			■					
8			■					
9			■					
10				■				
11				■				
12					■			
13					■			
14						■		
15						■		
16							■	
17								■

■ New Intervention; • Follow-up Intervention

Although all clients were informed in detail of the research purpose of Women's Health Project, the majority of clients agreed to participate for their own specific reasons, as the following quotes convey;

I was just diagnosed with Hep C about a month ago, [...] I've heard about it from other people comin' into clinics like this and they've told me different things, but I'd rather hear it from a doctor, from a doctor's point of view, the doctor it'd know more about it than most people that's why I came here.

(Homeless female client, 27 years)

I got a smear done in X[a hospital] and they lost the results so I'm anxious to get it done again. I want to get it done here cause me friend got it done and she reckoned it was okay, so I want to get it done here. Rather than goin' back to X and havin' another repeat because I was very worried when I was gettin' it done the first time, like I'm one of those worriers, I worry about everything ye know. The fact that I got it done with a man aswell was a bit nerve-racking for me. I'd rather get it done by a woman because she knows what's she doing.

(Female client, 28 years)

It was also perceived by some clients that the provision of a health care service within a drug organisation would be more sympathetic to their current drug status and also to any health complaints which might result from their drug using behaviour. The following quotes from the staff of the Women's Health Project illustrate these concerns;

They find that sometimes their own doctor doesn't understand. I had a client in this morning who said 'my doctor doesn't understand me injecting and ruining myself. That's not what they want to hear when they go there. Just accept them where they are and treat them accordingly.

(Female Nurse/Drugs Worker)

One of them [female client] said to me that she had been to doctors and that there was none of this 'eyeball to eyeball contact'. She said 'at least you're looking at me, you're talking to me, you're seeing me'. I was a little bit taken aback by that.

(Doctor of the Womens Health Project)

The majority of follow-up visits were initiated by the client with the intention of obtaining results of laboratory tests. These visits provided the client with an opportunity to highlight other emerging health issues or concerns. Furthermore, as clients became familiar with the existence of the project, they were more inclined to re-present. Table 6.2 below presents the nature of the follow-up visits which were undertaken by the 11

TABLE 6.2 TYPE OF FOLLOW-UP INTERVENTION

Follow-Up Intervention	Yes	
	n	%
Results	(11)	100
Specific Gynecological Complaints	(6)	55
Referral	(5)	45
Contraceptive & Reproductive Health Advice	(5)	45
Other Health Education	(4)	36
Injecting and Vein Care Advice	(2)	18
Wound Dressing	(2)	18
Drug and Alcohol Information	(1)	9

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clients who re-presented.⁹ As illustrated by Table 6.2, a large proportion of follow-up visits (55%; $n=6$) included dealing with various gynecological complaints among the clients. This may reflect the fact that clients were more likely to discuss such complaints as they were aware that the doctor was a gynecologist. In addition, 3 of the clients were pregnant.

6.2 Medical Assessment

As described in Chapter Three of the Report, a medical assessment form was designed for the purpose of this study and was completed by the doctor both during and upon completion of each consultation with a female client. The information collected provided a comprehensive overview of their current health status which was clinically assessed. It also included the results of a range of laboratory tests undertaken during the intervention.

This section will present information regarding clients' past medical history, surgical history, a review of systems and clients' gynecological issues.

6.2.1 History/Present Illness

Clients were firstly asked to report whether or not, they themselves, or any of their family members, currently experienced or had ever experienced, various diagnostic health complaints.¹⁰ Table 6.3 below illustrates the extent of these health complaints among clients and their family members.

TABLE 6.3 PERSONAL/FAMILY EXPERIENCE OF DIAGNOSTIC HEALTH COMPLAINTS

Complaint	Individual		Family	
	<i>n</i>	%	<i>n</i>	%
Asthma	(6)	38	(5)	31
Diabetes	-	-	(5)	31
Epilepsy	(3)	19	(2)	13
Heart Trouble	(1)	6	(2)	13
Hepatitis	(9)	56	-	-
HIV	-	-	-	-
High Blood Pressure	(1)	6	(6)	38
Malaria	-	-	-	-
Mental Illness	(13)	81	(3)	19
Tuberculosis	-	-	-	-
Venereal Disease	-	-	-	-

The table above illustrates that a large proportion of clients (81%) reported experiencing either presently, < in the past, some form of mental illness. Depression was cited as the most common complaint with 4 clients reporting very severe depression which had led to suicide attempts in the past. Over a third of clients (38%) reported being asthmatic with a further 19% being epileptic.

6.2.2 Surgical History

All clients were asked if they were ever hospitalised in the past. Eighty one percent of clients ($n=13$) reports having being in hospital for a time. Clients reported being admitted for a range of complaints including bir

⁹ This information is only compiled on the basis of written reports of the follow-up interventions. Verbal information which may have been exchanged to indicate the nature of the follow-up intervention is not included.

¹⁰ Although questions on hepatitis and HIV were previously included in the administration of the Health Information Form it was considered necessary to ask clients once again to report on these complaints to ensure that all the relevant information was available in order to undertake a comprehensive medical assessment.

of a child, road accident or routine surgical operations such as tonsils or appendices. However 3 clients had to be hospitalised as a result of suicide attempts in the past.

6.2.3 Review of Systems

Table 6.4 below presents a summary of the review of systems which were undertaken among clients. Results were divided into three categories; 'normal', 'abnormal' or 'refused/not evaluated'. All clients agreed to participate in this review. The table below illustrates that the greatest cause for concern refers to areas such as, the abdomen and the neck which are noted as particularly dangerous injecting sites. These areas demonstrated severe indentations or bruising, with 40% ($n=6$) assessed as being 'abnormal' at the time of interview. Skin abrasions were present among over a quarter of clients. In total, 60% ($n=9$) of the reviews identified prominent scarring and bruising of the injecting site.

TABLE 6.4 REVIEW OF SYSTEMS

	Normal		Abnormal	
	<i>n</i>	%	<i>n</i>	%
Head	(15)	100	-	-
Throat	(15)	100	-	-
Ears	(15)	100	-	-
Nose	(U)	93	(1)	7
Eyes	(U)	93	(1)	7
Chest	(U)	93	(1)	7
Neuro	(U)	93	(1)	7
Mouth	(13)	87	(2)	13
Extremities	(13)	87	(2)	13
Lungs	(12)	80	(3)	20
Neck	(12)	80	(3)	20
Genitals*	(12)	80	(2)	13
Skin	(11)	73	(4)	27
Abdomen	(9)	60	(6)	40

* One client refused this examination and so was not evaluated, this accounts for the remaining 7% not illustrated.

Other abnormalities illustrated in the table above, refer to systems such as the lungs, as the majority of these clients were asthmatic and also daily smokers. One client, reported inhaling heroin continuously resulting in poor lung air entry and nasal soreness.

During the medical assessment, both the weight and height of clients were reported. These measurements were then used to calculate the body mass index of clients-¹¹ Table 6.5 below illustrates the body mass index of participating clients.

Only 13% ($n=2$) were found to be underweight at the time of the interview. However, over half of the clients assessed were reported to be either obese or overweight. This may indicate a tendency towards sugary and fatty food as their primary food intake. As will be illustrated later in this chapter, a large proportion of female clients were found to be anemic at the time of interview. This would suggest that while these clients' body mass index may not be of concern in terms of food deprivation, the nutritional content of their food intake is open to question.

¹¹ Body Mass Index (BMI) is an objective scientific measure that assesses an individual on the basis of his/her height and weight. To determine your BMI, weight in kilograms is divided by height in meters squared. The algebraic expression for BMI is $\text{kg}/(\text{m})^2$. Values for BMI are as follows; Normal Range=20-25, Underweight =10-20, Overweight=25-30, Obese=30-40, Very Obese= 40-60.

TABLE 6.5 BODY MASS INDEX

Body Mass Index	Frequency	
	<i>n</i>	%
Obese (1 pregnant 24 wks)	(3)	20
Overweight (1 pregnant 20 wks)	(6)	40
Underweight	(2)	13
Normal (1 pregnant 12 wks)	(4)	27

6.2.4 Gynecological Issues

All participating clients were asked to state whether or not they currently experience any gynecological complaint. Seventy-five percent ($n=12$) reported having at least one gynecological complaint. Table 6.6 below illustrates the nature of these gynecological issues.

TABLE 6.6 GYNECOLOGICAL ISSUES

Gynecological Issues	Yes	
	<i>n</i>	%
Secondary Amenorrhea	(5)	42
Spontaneous Abortion	(4)	33
Pregnant	(3)	25
Induced Abortion	(2)	17
Irregular Menstruation	(2)	17
Infertility	(2)	17
Ectopic Pregnancy	(1)	8
Ovarian Cyst	(1)	8

A large proportion of clients (42%; $n=5$) reported secondary amenorrhea, with one client reporting not having had menstruated for the last seven years. This is well documented in literature on women and drug use, which states that the prolonged use of some drugs can suppress menstrual periods. This may result in pregnancy among some women not being detected until a late stage in their pregnancy.

Over a third of those with gynecological complaints also reported having had a spontaneous abortion. The following client tells how her pregnancy suddenly ended when she was six months pregnant;

I was six months pregnant and at six months they had to induce me and do a scan, because they couldn't find a heartbeat. I knew there was something wrong because I was gettin' movements all the time and then all of a sudden they just stopped, the blood stopped going through her body and she stopped growing, so they had to induce me.

(24 year-old client)

Another client reported having had very severe morning sickness during her pregnancy with her second child. She recalls how it resulted in her blood count getting low and how she was then admitted to hospital;

I had very bad morning sickness all the way through to me fourth or fifth month getting it every day. I was getting sick that bad I couldn't eat anything I was getting very thin. There was very little oxygen in me blood so I was taken into hospital. Me lips were blue and I was dehydrated.

(Regular client)

As already mentioned, of those clients who participated in the medical assessment of the research project, a substantial proportion were pregnant. One client in particular reported how she felt anxious and scared about her

pregnancy due to the fact that it was her first time expecting while on methadone. She acknowledged the support she was currently receiving from the midwife liaison scheme and how she can make contact at any time.¹²

It's my first time to have a baby on methadone, I wasn't on anything before. I'm going into X to see can I cut down, there's a mid-wife that I see every week and I go to her if I want to know anything and if I have any worries about anything I can just ring her she's good, very good.

(28 year old regular female client)

Homelessness can further increase the health risks to which pregnant female clients are exposed. The following quotes convey the difficulties that homelessness can place on the health of both the client and pregnancy outcomes;

I'm not on heroin at the moment because I'm pregnant. I went into X and I was there seven and a half weeks. When I got out of X and because I was homeless I was waiting for accommodation I got pneumonia. I was only out two days when I was in hospital. They couldn't get any of the fluids in I was dehydrated, they couldn't put the drip anywhere in me because I've no veins left from using.

(28 year old regular client)

I've never been pregnant and homeless, I've been looking at a lot of girls, and imagine being pregnant and homeless and on drugs aswell, how would you cope? Like it's bad being homeless but pregnant aswell, trying to look after yourself and then the pregnancy and maybe at the end of the night having no bed to sleep in. I know a girl who slept on the streets that was pregnant. I actually slept on the street with a girl that was pregnant.

(43 year-old female client)

6.3 Investigative Screening Tests

As already stated a range of investigative screening tests were offered to clients in addition to the medical assessment. These tests included the following;

- Full Blood Count
- Liver Function
- Renal Function
- Random Cholesterol and Blood Glucose
- HepA,B & QHIV,
- STI Testing (Syphilis and Chlamydia)
- Vaginal Swab and Cervical Smear

In total, 87% (n=13) of clients agreed to undergo at least one laboratory test. As already mentioned in the previous chapter, some female clients reported having recently undergone specific tests such as Hep B/C and HIV at their methadone clinic or as routine tests undertaken upon disclosure of their pregnancy. *Table 6.7* below conveys the scale of these tests.

A large proportion of female clients expressed an interest in having a range of tests. Clients were extremely concerned about being tested for specific sexually transmitted infections and vaginal or cervical smears. As will be discussed later on in this chapter, difficulties were encountered in obtaining a sufficient amount of blood for the samples from seven clients, due to the poor quality of their veins.

¹² Eastern regional health authority liaison midwives work specifically with pregnant drug using women who are attending maternity hospitals in Dublin. The liaison midwife acts as a link between the obstetric and the drug treatment services to ensure that drug-using women receive a comprehensive service and to ensure good communication exists between these two teams.

TABLE 6.7 LABORATORY TESTS UNDERTAKEN

Laboratory Tests	Yes	
	n	%
Vaginal Swab	(11)	73
Blood Count	(10)	67
STDs	(10)	67
HIV	(9)	60
Hepatitis C	(9)	60
Urine Tests	(8)	53
Hepatitis B	(8)	53
Cervical Smear	(7)	47
Other*	(2)	U

* Glucose test

Overall, 67% (<=10) of clients agreed to have a full blood count undertaken. Of these, 70% (w=7) were found to be anemic at the time of interview, as *Figure 6.1* below illustrates.

FIGURE 6.1 ANEMIA AMONG FEMALE CLIENTS



One client in particular reported having experienced anemia on numerous occasions which had often resulted in her having to undergo various blood transfusions in the past;

I got a blood transfusion lately, I'm anemic and I have to have blood transfusions, [...] I've got about eight blood transfusions in the past me blood keeps going back down and I need another one again. They don't know where me bloods are going, they did loads of different tests. I know its gone down again because every few minutes I end up stopping cause I get dizzy and then I get sweaty.

(43 year-old client)

The majority of clients reported consuming a great deal of convenience food. Diets usually comprised of large amounts of sugar, fat, salt and caffeine with very few clients reporting a balanced and nutritional intake. As the majority of clients were currently "out of home" this was further aggravated by the lack of facilities in which to prepare and store food. Clients reported heroin as suppressing their appetite, and did not therefore require food at times.

Years ago I used to eat a normal dinner but now I get this bland taste in me mouth, I now eat sugary stuff cause I know I get a taste out of sugary stuff, like chocolate and cakes instead of eatin' a proper dinner.

(Client; 31 years)

Most of me teeth are in bits because of the gear [...] eatin' all the sweets and chocolate and minerals, all the fizzy stuff, when you 're on gear you don't eat properly.

(28 year-old regular client)

Table 6.8 below demonstrates the positive results of tests which were undertaken over the eight weeks. These results confirmed and in cases provided an opportunity to dismiss clients' self-reported information. It is clear from the table below that the substantial majority of female clients had positive hepatitis C antibodies present.

TABLE 6.8 POSITIVE TEST RESULTS

Test	Frequency	
	n	%
Hepatitis C (Antibodies Present)	(13)	87
Hepatitis B (Antibodies Present)	(2)	13
Abnormal Liver Tests	(3)	20
Abnormal MSU	(1)	7

However, hepatitis C antibodies can indicate either present or past infection. The above clients may have the antibodies for Hepatitis C, but what is of most concern is the extent to which the liver is affected. In this regard, the tests convey that only 3 female clients reported an abnormality in their liver function. One of these clients is currently receiving treatment for chronic hepatitis. The following quote illustrates the pain which she experiences;

/ have chronic hepatitis. I feel grand now, though I was very sick now I'm better. I'm not as tired as I used to be. I used to be sleeping all the time I used to be very yellow and have pains across here [her chest] ye know right across. Like I attended the hematology unit every month. Since I came pregnant there's not much they can do unless take me liver function.

(Regular Client)

6.4 Evaluating the Intervention

In this section, data is presented from the interviews conducted with the staff which were involved in the Women's Health Project, namely the doctor, nurse and the female drugs worker. The interview focused on the implementation of the Women's Health Project over the eight-week period and provided an opportunity to highlight any positive or negative elements of the Project.

6.4.1 Service Environment

From the onset, the importance of establishing the Women's Health Project within an existing familiar and convenient location for the female clients was considered to be of utmost importance. It was felt that both access to, and participation in the Project would be greatly enhanced if it was located within a low threshold service within Merchants Quay Ireland. Incorporating the Project within the regular services provided by the Contact Centre proved beneficial both in terms of the management and delivery of the interventions undertaken as the following quotes convey;

/ think it was much better having it there on the spot where they knew us. If they didn 't know me they knew X or they could chat to other female workers.

(Female Nurse; Drugs Worker)

/ think it was a very good idea not to have it as a separate service, when the place was closed. I think it was very important that it occurred when other services were going on [...] However while the clients were very much open to what was happening they did like the privacy of it. That is why I feel they liked to have the other services going on at the same time, moving continuously like they do usually and that they could then avail of the doctor if they wanted to.

(Female Drugs Worker)

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People living on the margin are not good at keeping appointments. You can tell them to return tomorrow or the day after and they may or may not. What is important for them today may not be important for them tomorrow morning. In this way the Women's Health Project was good.

(Female Nurse; Drugs Worker)

The suitability of the location of the Project was also reflected in the extent to which clients were at ease when they presented for their medical interventions. Clients were aware of the limitations of the Women's Health Project in terms of it being primarily an eight week pilot study.

They came in very calm and weren't distracted at all by what was happening outside. That is what amazed me. The first morning we had X [a client] who had to rush out, but after that they were ready to spend time inside and they were in no hurry. X had to rush out and make a phonecall and I thought this would be a very regular thing but it wasn't at all. But there was no rush on them [...] they were very open and very relaxed with the doctor.

(Female Nurse/Drugs Worker)

I felt that the women themselves were very helpful and by the time they had reached us I felt that they were very well prepared even before they reached the doctor at all. They were very clear in their minds about what they were about to experience in the clinic and they were most co-operative.

(Female Nurse/Drugs Worker)

The first intervention with the doctor obviously is for the women quite a nervous and anxious, experience. Reassuring them is invaluable, reassuring them that it is as narrow or as broad as they want, that they can ask the doctor anything, have any tests or examination done, or they can have nothing done [...] That first intervention is brilliant because it is so easy to avail of. They feel they can come back and have a quick consultation with the doctor and check out something they weren't quite sure about. It's so acceptable because they are here nine times out of ten anyway.

(Female Drugs Worker)

6.4.2 Service Delivery

In view of the highly medical nature of this research study, strict planning and preparation of activities were necessary to ensure its smooth operation. Contact with a range of medical service providers within the locality, provided information on issues such as, equipment and relevant protocols including the transport of specimens. This greatly influenced the effectiveness of the Project;

We contacted X [a medical service provider] and got all our instruments and all our materials. Through our organisation in the early stages it went very very well.

(Female Nurse/Drugs Worker)

Any difficulties experienced mainly occurred within the early stages of the Project. Following the initial morning of the Project, medical interventions continued favourably;

I found the first day the most difficult of all. After that I felt that the doctor and myself settled down very much into it and got on well with the clients.

(Nurse/Drugs Worker)

The greatest difficulty was in obtaining adequate supplies of blood for laboratory tests due to the poor quality of the clients' veins. As the doctor explained;

It was very difficult getting the blood. From the first two we made a lot of mistakes because we didn't have the right amount of blood. I hadn't anticipated this difficulty. I think the

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In total, she presented for four follow-up visits. Her test results were disclosed, and she was treated for a large inflamed abscess. She was given other health related advice and information. Her test results indicated that she was in fact only hepatitis C positive and that both hepatitis A and B were negative. Syphilis was also negative and her cervical smear was normal. A referral was made to Trinity Court for a rapid assessment for a methadone programme.

Client B

Sue is 23 years of age. She is currently 'out of home' and is temporarily staying with friends. She is currently injecting heroin and has been injecting for the last year. Over the last four weeks she has also injected Benzos and is also ingesting street Valium and Dalmane.

At 16 years, Sue had an induced abortion in England. She reported that it had been found at a very early stage that her cervical smear was abnormal. Other gynecological complaints included secondary amenorrhoea for the last 3 years.

Upon examination the doctor found her to be very tender and to have a bloody cervical discharge, indicating that it was perhaps an ectopic pregnancy. She was then referred immediately for a scan and the results conveyed that it appeared to be an ovarian cyst (a dermoid cyst). Following a meeting with the gynecological consultant in the hospital, Sue received a surgery date.

Results of laboratory tests undertaken during the Women's Health Project also revealed that her cervical smear was normal with no signs of pre-cancerous cells despite what she had reported verbally. Syphilis was negative and also Hepatitis B, C and HIV.

6.4.3 Women's Health Project- Raising Awareness

The Women's Health Project was primarily an investigative research study, however the participating clients presented real and pressing health concerns. For some clients the disclosure of test results did not greatly concern them, as they were already aware of specific results which merely verified previous findings. Overall the majority of clients were in receipt of positive results with only a small proportion highlighting issues for concern;

The majority of reports were very good. Those who were informed of their hepatitis C, these women had already tested for hepatitis C and they knew that they had it or they didn't have it and they accepted it. When they found that their vaginal smears were clear also, it was such a great relief to them.

(Nurse)

They may have hepatitis but if their liver is okay, then it is good. You can have antibodies and that just means you have an infection but if it's not actually affecting your liver then that is very good news. A lot of them have positive antibodies for hepatitis C but how many actually have the virus. Two of them that are positive maybe three. When I reviewed their liver function tests were abnormal.

(Doctor)

The Women's Health Project also highlighted that the majority of women involved in the research study were aware of, and placed immense importance on their health. It illustrates that these women are highly concerned about maintaining their health and well being, over and beyond seeking medical treatment for an immediate health care complaint, despite what is often reflected in both the type and frequency of medical contact pursued.

These women are taking care of themselves. They are very much aware of their health and what could happen. They worry about their health [...]. How they have looked after themselves that's what I would say to you, it is a credit to them. They are responsible people.

(Female Nurse)

/ think they are very concerned about their health but I think they are looking for a quick solution. They need to change their behaviour; it's behavioural change within their lifestyle that's the big thing.

(Doctor)

However, frustration was also expressed by the limitations at the restrictions placed on the number of clients that could be facilitated on any one morning.

/ suppose I would have liked to see more women naturally but then we couldn't find the women in the morning. If we could have seen women in the afternoon maybe 2-4 aswell I don't know [...]. It opened my eyes to realise so few women come in the morning. Maybe they come in at half eleven or twelve o'clock because of children or one thing or another. I'll now be observing in the afternoon how many women actually come in the afternoon.

(Female Nurse)

A morning is an extremely short time and that it is fine on the first day when you could probably see three clients. But we found that this wasn't a reality. Two new clients with the intervention that the doctor was giving was more than enough. Then as we saw more clients and as clients were also coming back to get test results it definitely proved to be enough.

(Female Drugs Worker)

A small proportion of clients also required on-going treatment. The fact that there was no guarantee that they would receive follow-up care was frustrating for the staff;

It's a little bit frustrating in a way for me personally because you don't know what is going to happen to them in the future. You've done all these tests. You know that there is one or two of them that need very urgent follow-up and you don't know if they will receive it. I do feel that the thing is a little bit fragmented, for me as a doctor anyway. I have experience where you have being working and following up with whatever intervention has been made and it has been sustained and passed over to others. With these girls it's a bit messy and it's because of their lifestyle.

(Doctor)

The experience of the Women's Health Project, shows that the establishment of a similar project on a longer term basis would be necessary if this group were to have access to health care appropriate to their needs and circumstances. Follow-up care of these individuals would provide them access to a range of other services which are available.

/ think if you are going to set up a primary health care service here, this is going to solve a lot of those problems. It would be in one place and they would feel that there is somebody that is concerned and they are going to be followed up [...] I think it is necessary because of their lifestyle. Like X [a client] who went to the hospital. If she had been told to go herself she wouldn't have gone, or if she had gone she mightn't have stayed. It was the fact that somebody went and accompanied her. That's where they are at.

(Doctor of the Womens Health Project)

The teamwork element was very good. I think a few of them [female clients] were even referred onto acupuncture here and some alternative medicine also. The learning for me has been that a system like this can work if you have people working together as a team exploring other avenues like complementary medicines, which you are already doing.

(Doctor of the Womens Health Project)

6.5 Summary and Conclusions

This chapter has outlined the nature of the medical interventions undertaken as part of the Women's Health Project. These interventions primarily aimed at achieving a medical assessment of clients in addition to various investigative screening tests. The information collected from these two sources complemented the self-reported data documented in Chapter Five of the Report. Fifteen clients agreed to participate in this element of the study. A total of 33 interventions were made which included 18 follow-up interventions on 11 clients within the eight-week period. Numerous other clients expressed an interest in participating but it was not possible to accommodate all requests.

The majority of test results were favourable. Those to whom negative results were disclosed had prior knowledge of their results in the majority of cases. Nonetheless, 87% ($n=13$) of client cases were revealed to have hepatitis C positive antibodies and a further 13% ($n=2$) had hepatitis B positive antibodies. However, on receipt of the liver function tests only 23% ($n=3$) of those with hepatitis C antibodies were found to have liver abnormalities. It is also worth noting that over half of the clients interviewed reported having being tested within the last year. It may be the case that the potential severity of hepatitis C has not yet surfaced.

The numbers of clients seeking gynecological advice and more specifically pre-natal information as a feature of their intervention were high. As already stated, 24% ($w=4$) of those who agreed to participate in the study were pregnant at the time of interview. This supports international research which suggests that pregnancy can provide the opportunity to encourage drug-using women to enter treatment and to change their behaviour. Furthermore, the provision of obstetric services may be the route to treat other problems related to drug use (Hepburn, 1996; MacGregor, 2001).

Conclusions and Recommendations

The invisibility of women within many drug services remains a highly debated issue for concern. Women drug users represent a mobile and often 'hard to reach' group. Evidence suggests that they are often deterred from seeking treatment due to a range of factors, including economic resources and childcare concerns (Hodgins *et al*, 1997; Swift *et al*, 1996; NIDA, 1998). Moreover, treatment is often provided within a male orientated environment with the needs and circumstances of female drug users remaining largely unacknowledged (Reed, 1987; Ettorre, 1992).

This study has focused on an investigation into the health status of female drug users in order to ascertain the degree to which their medical needs are met. A Women's Health Project was opened for one morning a week over an eight-week period. During this time, detailed medical assessments, in addition to a range of clinical screening tests were undertaken among a cohort of regular attendees at the Contact Centre within Merchants Quay Ireland. A total of 33 interventions were made which included follow-up or repeat visits by clients. This clinical information was complemented by clients' self-reported data on their health status and levels of contact with medical services.

There is a belief that drug users are not interested in health care and that the need for health care arises purely from behaviour which is often seen as self-inflicted (Brettle *et al*, 1990). However, this study has highlighted that female drug users, in particular, are highly aware of and concerned about their overall health and well-being beyond immediate health care complaints. This study has also demonstrated that a complex relationship exists between their need, their demand for and use of health services. Numerous factors, such as the perceived insensitivity of medical service providers to their circumstances and negative attitudes among health care professionals can limit female drug users access to, and participation in a range of medical services. This can often result in their increased use of emergency services instead of seeking assistance within the primary care setting.

This project has provided a "snap shot" of the current health status among a cohort of female drug users. Although the majority of assessments were positive, it must be noted that the potential risk of deterioration is ever present. By minimising existing harmful behaviour and providing the female drug user with appropriate follow-on support and access to medical services, it may be possible to maintain stability. Nevertheless, female drug users, regardless of their current health status, represent a case for special consideration.

Recommendations

Based on the findings and learning of the Women's Health Project, the following recommendations are made; The general drug-using population is not a homogenous group. Individuals engage in different patterns of drug use and behaviour. Women have been highlighted as a group whose drug-using practices include extreme use of psychotropic drugs in addition to the regular use of other illicit substances. In this regard, female drug users represent a case for special consideration and the following recommendations are therefore presented;

- *Gender differences in approaches to medical diagnosis, intervention and prevention must be examined and employed;*
- *Consulting women with regard to their health needs will help develop services, which are appropriate to their needs and circumstances;*
- *In promoting positive health care practices the aim should be to maximise the health of the individual by creating a model to which the drug user can relate. Health services, therefore, must be flexible and resourceful in adapting to the differing needs of this client group.*

A fragmented service delivery limits the possibility of providing a continuum of health services to meet the complex needs of female drug users and those of the general drug-using population. We should therefore;

- *Work on the basis of a comprehensive assessment of the women's situation and apply case-specific care and treatment planning techniques;*
- *Have a linked service model of care whereby individual case files can be accessed by health professionals. This would ensure both continuity and follow-on care;*
- *Adopt a broader focus to health to include access to primary health care, reproductive health services, pre-natal care and behavioural health services.*

Lack of primary health prevention strategies and deferred use of secondary care, means that treatable infections and complaints are left unchecked, potentially leading to serious or fatal consequences. To minimise such harm, the following health promotion strategies are recommended;

- *Routine regular contact with drug users to include running through a health checklist to increase early detection of medical complaints;*
- *Provide a wide range of health services in a local setting which are user-sensitive, culturally specific and readily available;*
- *Regular liaison and co-operation between drug, health and other social services to provide coordinated care and follow-up support for drug-using clients;*
- *Develop a comprehensive hepatitis C strategy which focuses on raising awareness, preventative care and treatment options;*
- *Provision of on-site counselling to deal specifically with psychiatric complaints among this client group.*

Access to primary health care is often influenced by a range of social and economic factors. Access to and participation in healthcare services could be improved by;

- *Ensuring that all drug services have a Welfare Rights person to inform clients of their health entitlements and provide assistance in dealing with these issues;*
- *Ensure that the process involved in the application of medical cards under the General Medical Scheme is made more user-friendly. In this regard, consideration should be given to reduce the tedious and time-consuming element of both applying for, and processing the card. Extending the expiry period of medical cards is also recommended;*
- *Providing drugs awareness training, education and information to health care professionals who work with women who use drugs and drug users in general;*
- *Drug services should develop and employ specific outreach efforts to draw women into treatment or that direct them towards services that can cater for their overall health care needs.*

The provision of appropriate and adequate health care for female drug users should be firmly placed on the political agenda to ensure that health strategies do not further marginalise those in greatest need of care. Therefore, the following are recommended;

- *Ensure that research findings and policy decisions are turned into effective women's health programmes;*
- *Develop and implement effective women's health policies and programmes at a local and national levels.*

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