Guest Editors’ Introduction

Urban Women & Problematic Substance Use: Framing the Issues

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Health is arguably one of the most important issues for local and international governments, health authorities, community groups, health professionals, educators, policy makers and activists. As public interest in health grows and budgets shrink, there is greater need to find innovative and effective ways to protect health and promote healthy communities through the development of healthy public policy. There must also be effective programs and services responsive to the evolving needs of specific populations in various locales.

This special issue is concerned with the health of urban women with problematic substance use. The health literature uses a variety of terms to describe drug use, abuse, misuse, dependence and addiction. These terms have different meanings depending upon whether they are used in a public health, legal, or colloquial sense. The choice of terms also reflects the assumptions and political leanings of those using the terms. For instance the term illicit drug use appears to be a term favoured in the National Anti-Drug strategy where the emphasis is on the legal or criminal aspects of drug misuse. Our choice of terms such as problematic substance use follows the lead of Poole and Greaves (2007) and is consistent with the feminist politics and goals of this journal and the emphasis we, as guest editors, place on contextualizing women’s drug use and health outcomes.

Four interrelated themes frame this special issue about the health and experiences of Canadian and Australian urban women who misuse drugs and the community-driven and research-based strategies for promoting and protecting their health. The first factor is the political relevance of a gender-based approach to women’s health in general, and substance use in particular. Although the degree of financial and discursive support for gender-based health research from funding agencies and government organizations has varied over the last two decades, there is little doubt that researchers are paying greater attention to health issues of importance to women, and to the social determinants of health disparities among women. Health determinants are those factors or influences that shape the health of individuals and communities. The Public Health Agency of Canada (2001) identified twelve health determinants: gender, income and social status, culture, social and physical environments, education, employment, social supports, health services, healthy child development, personal health practices and coping skills, and biological and genetic endowment. Each is important in its own right but the interrelated effects of these factors determine population health outcomes. Therefore, the interconnectedness of gender with other determinants is central to exploring women’s health outcomes and the disparities among women. Despite this growing respect for gender-based analysis of health issues, there has been relatively little attention to the gender differences in substance use.

One of the challenges to investigating the incidence, type and extent of substance use is the illegal nature of some drug-related activities, the stigma associated with problematic substance use, and the challenges of collecting data from those living with drug and alcohol-related cognitive changes and mental health issues. Women in particular may under-report substance use because they fear that their minor children may be apprehended (Health Canada, 2001). Moreover, over-consumption of alcohol, cannabis, prescription drugs, if not acceptable, is generally better tolerated than the problematic use of other substances such as cocaine and heroin. Additionally, substance misuse by some groups of women (the white urban professional, for example) is generally better tolerated than misuse among other groups of women. As Boyd (2004) points out, research tends to focus on non-white women, pathologizing their drug use as individual lifestyle choice gone awry, and decontextualizing the circumstances in which the problematic use occurred. Thus research and the recommendations that emerge have tended to focus on problematic women who abuse drugs rather than women with problematic drug use.
The Canadian Addiction Survey (CAS) conducted in 2004 by the Canadian Centre on Substance Abuse is the most recent and comprehensive national survey of substance use issues (Adlaf, Begin & Sawka, 2005). Ahmad, Poole and Dell’s (2007) gender-based analysis of CAS findings offers some insight into women’s use of alcohol, cannabis and other illegal drugs, the role of income adequacy, education, marital status and other factors on women’s patterns of use and the harm linked to problematic substance use.

Alcohol is the substance most commonly used by women (Ahmad, Poole & Dell, 2007). Heavy alcohol use (defined in the CAS as four or more drinks in a single sitting at least once a month) is highest among women aged 18-24 years, single and never-married women, and women with the lowest income levels. As women’s reported alcohol intake increases, so too does the level of alcohol-related harm to their physical health (11.4%), social life (10.1%), home life (4.7%), employment (4.4%) and financial situation (4.3%) (Ahmad, Poole & Dell, 2007). The Australian Institute of Health and Welfare (2007) notes that 10 percent of Australians drink at a level considered risky for long term use. Given the rates of over-consumption and health-related harms, we (as guest editors) were surprised that none of the manuscripts submitted for this special issue addressed alcohol misuse among women.

Cannabis use among Canadian women is also on the rise. Prevalence rates among women aged 15-19 years more than tripled, from 10.3% in 1989 to 34.1% in 2004. For women aged 20-24 years, prevalence rates more than doubled from 13% to 30.7% during the same period (Ahmad, Poole & Dell, 2007). Among Australian women, cannabis was the most frequently used illicit drug with 34% of the population reporting that they had used this substance during their lifetime (Australian Institute of Health & Welfare, 2007). In the earlier Australian Longitudinal Study of Women’s Health, of the women aged 22-27 years who reported drug use in their lifetime (n=9512), 57% had used cannabis (Turner, Russell & Brown, 2003). Similarly, we received no manuscripts that addressed cannabis use among women.

Use of other drugs such as cocaine (including crack), hallucinogens, speed, ecstasy and heroin use is less common among Canadian women (1.8%) than among Canadian men (4.3%) (Ahmad, Poole & Dell, 2007). Use of these illegal substances peaks among women aged 20-34 years with higher prevalence rates among single and never-married women and women with some post secondary education. Rates of drug-related harm reported by women using drugs are significantly higher than those associated with women’s problematic alcohol use. Women surveyed who admitted to illegal drug use in their lifetime (n=997) reported harm to their physical health (27.9%), social life (16.9%), marriage and home life (15.3%), employment status (15.2%), financial position (15%), and learning (11%), as well as legal problems (4.3%) (Ahmad, Poole & Dell, 2007). A chilling statistic that highlights the harm associated with problematic drug use comes from study of injection drug use among young people. Young females who inject drugs are 54 times more likely to die prematurely (compared to men who inject drugs who are 12.9 times more likely to die prematurely) than Canadians who do not inject drugs. The leading causes of death were homicide, suicide and drug overdose with other associated factors being HIV infection and sex work (Miller et al., 2007).

Rates of illegal drug use among young Australian women are comparable. Among those who reported using an illicit drug in their lifetime, 15% had used ecstasy or designer drugs, and 14% had used LSD (Turner, Russell & Brown, 2003). According to the Australian Institute of Health and Welfare (2007), women with a diagnosis of cannabis, stimulant, or opioid use had a higher incidence of low birth weight babies than those without this diagnosis. Additionally, women with low birth weight babies and a diagnosis of cannabis, stimulant and opioid use were more likely to be younger, unmarried, Australian born, and indigenous.

Poole and Greaves (in this issue) explore the hotly contested issue of how to balance the interests of mothers with problematic substance use and the interests of their unborn and dependent children. The authors challenge the risk-based assessment which currently guides Canadian federal and provincial child protection policy and practice, proposing instead a values-based policy framework that intends to balance the needs of mother and child. They report on
the responses of health practitioners and policy makers to the proposed policy framework and identify the obstacles to implementation. They expose contradictions in deeply held values about the interests of the child, the rights of mothers and evidence that questions the effectiveness of existing policies that guide everyday practice.

Gender-based research exposes the wide range of harms experienced by some women who misuse drugs. This is the second theme running through the articles in this special issue. A gender-based analysis reveals how differences in social location (indigenous status, income adequacy, age, social support) organize women’s access to social power and resources and determine their health experiences and drug-related harms. The following poem entitled ‘Gramma’ unsettles simplistic caricatures of women and substance use common in the media offering instead a more complex portrait of the links between subjective, embodied health experiences and the structural factors that shape women’s experiences with drug use and associated health outcomes.

GRAMMA
She was an entrepreneur, owned a jewellery store. She says.
Does have a pair of earrings that appear to be real gold.
Weighed 170 pounds before crack, before divorce, before homelessness.
Was a much-wanted 1940’s baby,
Raised in a strict Catholic home, taught to be a good cook, knows how to sew.
How long ago did the nim-binning grey-grunge grow right into her nails?

In the previous millennium she had a yard to tend,
flowers with names & needs, children who respected her,
an admired role & place in the community.
Did she always judge others so critically—pick pick put down put down?
Did her 90’s crash-burn-fall turn her into a bizarre hoarder?
Dozens of bags & boxes stacked, tumbling, squished…
Does she nag-pick-nag at others so they’ll hurt her?
Is this something like self-mutilation; outsourcing of her abuse?
Months witnessing her: now I note the zig-zag-zig of her & feel it less.

The first times she wept to me about her purse being stolen,
her face being beaten, her body being marked up—she said
she’d no idea why people were so mean to her.
Now I see when crack’s crazing her eyes,
causing her to steal, insisting her mouth fill with lies,
Crack is her, is her choices & their wretched consequences.
Like other too-long-here droopy-faced women
her half dozen teeth are infected (she sells her painkillers sometimes).

The worrisome weepiness, the raspy frightening cough.
The illnesses taking their toll on her…
She hurts when she’s forbidden to see her grandchildren.
Her dog was long ago rescued by family.
Anyone who knows her knows that most of her ‘I-ness’
has been eroded, confiscated, replaced by addiction.
Among those crazy bags & boxes stacked around her teeny ill-kept room
She giggles & assures me she’s been collecting
cute stylish gifts to send to her kids & grandkids for Xmas &
like a magician, she swirls & flags them for my viewing pleasure (Transken, 2008a).

Research that increases awareness of gendered patterns and determinants of problematic drug use supports the need for specialized women-centred services that differ from traditional or masculinist treatment programs (Dell, 2007). A media release supported by the Australian Drug
Foundation (2001) notes that gender specific services are required for women with problematic drug use where issues such as physical and sexual abuse can be discussed in a safe environment. Because many women seeking help have dependent children, services must also provide child care services. The Canadian Public Health Association (2005) also supports the call for gender appropriate programs to address documented differences in women’s and men’s experiences.

Strega, Casey and Rutman (in this issue) discuss their evaluation of a Canadian treatment program designed to meet the specific needs of women sex workers with problematic substance use. They identified several factors contributing to the program’s success: acknowledging that sex workers are a heterogeneous group of women, valuing women participants’ experiential knowledge, honouring harm reduction principles, and building peer support into the program. Although, the program was successful, the authors recognize that broader issues such as structural inequalities including gender, race, class and ability need to be addressed before significant changes can occur.

One of the most life-threatening of harms for women who use drugs is a blood-borne infection such as Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV). Risk is increased among women who inject drugs and is associated with sharing needles and other drug paraphernalia, and the unsafe disposal of needles. Women (and men) who exchange sex for drugs or money to buy drugs are also at risk of harm associated with unsafe sex practices. The National Centre in HIV Epidemiology and Clinical Research (NCHECR) in Australia identifies HCV as a major harm associated with injection drug use noting that about half of the women who inject drugs are HCV anti-body positive (NCHECR, 2006).

Banwell, Dance, Olsen and Dixon (in this issue) report on interviews conducted with 109 Australian women with known opioid use and HCV infections. That investigation of women’s sexual health and contraceptive needs raised concerns about the potential effects of opioid use on the reproductive and sexual functioning and specifically the effects and implications of opioid use on women’s estrogen levels. Although much is known about hormonal responses in other female populations such as menopausal women and girls with anorexia, there is little attention to this aspect of sexual health among women who use opioids or who are HCV positive. In the absence of such research, the health and reproductive concerns of this population of women will continue to be unrecognized and unmet.

HIV is the other blood-borne infection for women who use drugs. Women account for half of all HIV infections globally (UNAIDS, 2008) with Canada’s highest prevalence of infections among women and young Aboriginals (Silversides, 2006). The Public Health Agency of Canada (2008) reports that 41.5% of positive HIV tests in women aged 15-19 years are attributable to injection drug use. In 2005, the Canadian Public Health Association reported that Canada is currently lagging behind many other countries of the global north on HIV/AIDS related research.

Today, national and international funding priorities are shifting toward support for research about substance misuse and associated public health problems. Currently, organizations such as the Canadian Institute for Health Research (CIHR) consider HIV/AIDS a research priority meaning that well developed research proposals that focus on HIV/AIDS and problematic drug use have a potential funding source. However, increased attention to HIV/AIDS has not translated into concern for the health issues faced by women and girls. In June 2006, Stephen Lewis, the UN Secretary General’s special envoy for HIV/AIDS in Africa and a commissioner of the World Health Organization’s Commission on Social Determinants of Health addressed delegates at the Humanities and Social Sciences Federation of Canada Congress held at York University. Lewis urged Canadians to pay greater attention to health and education issues faced by women and girls around the globe.

Lewis’ call for greater attention to gender differences stood in stark contrast to the relative neglect of women and girls’ issues at the 15th International AIDS Conference held in Toronto later that same year. Few papers addressed women and HIV/AIDS in general or the associated links with problematic drug use. The sluggish growth of research on women, substance use,
HIV/AIDS and gender-specific strategies for harm reduction reflected in the 2006 AIDS Conference proceedings and the broader literature appears to be at odds with the national and international gender rhetoric—a situation Ali and Bushee (2006) characterize as “big words, little money.”

The third theme central to this special issue is the increased community and research-based attention to harm reduction as an approach to problematic drug use. Harm reduction is a public health concept that focuses on reducing the negative health consequences resulting from engaging in high risk activities (Health Canada, 2005). A risky activity is any behaviour that exposes an individual to the possibility of unpleasant or dangerous outcomes including personal loss, injury, illness or death. Some activities entail more and different risks than others. Two examples of risky behaviour are injecting illicit drugs and engaging in unprotected sex.

The harm reduction model assumes that people take risks as a normal part of every day life. However, some women (and girls) are more vulnerable or have less capacity than others to manage risks effectively. Factors such as poverty, racism, homophobia, social isolation, past trauma, and other social inequities can affect an individual’s vulnerability to and capacity for dealing effectively with risk. Women become harmfully involved in substance use for many social, economic, physical health, mental health, and personal reasons. For example, previous experiences with rape, incest, or intimate partner violence may make some women less able to effectively manage their drug use (Poole & Dell, 2005). The harm reduction approach acknowledges that harmful involvement with drugs goes beyond individual choice to broader social determinants and shifts our attention from an individual approach to drug misuse to a collective or social responsibility model.

Harm reduction is widely considered one of the most effective tools for addressing the health and social problems related to risky activities (Brown et al., 2005; Ettorre, 2004). This approach has been shown to work in both transitional economies and high-income countries of the global north (UNAIDS, 2000). Unlike the abstinence programs which focus on supporting individuals who are ready and willing to end their substance use, harm reduction programs seek to minimize the harmful effects associated with engaging in risky behaviours. Harm reduction strategies for women intend to empower them to better manage their own health risks. This approach meets women ‘where they are’, that is, respecting, honouring, and supporting a woman’s decisions. Such non-judgement and non-coercive support may include accepting a woman’s decision to use drugs or engage in other risky activities while simultaneously offering tools for dealing more effectively with risk.

The harm reduction model also recognizes the importance of structural supports. While creating and sustaining effective programs and services may not be feasible in all urban locations, a formal harm reduction infrastructure of explicitly defined and strategically placed linkages across existing programs and services may support healthier outcomes for women engaging in drug misuse and sex work. Key supports might include needle exchange programs, supervised safe injection sites, free health care, voluntary and anonymous testing and treatment for HIV, HVC and other infections, and methadone treatment programs.

Safe spaces staffed by health professionals and peer support workers is one way to share information about safer sex and injection practices, to direct women to appropriate health services, and to establish supportive relationships among women. Bungay, Johnson, Boyd, Malchy, Buxton and Loudfoot (in this issue) report on the effectiveness of engaging inner-city women in making safe crack-smoking kits. Kit-making was one of several woman-centred harm reduction activities that was evaluated in this Canadian university-community.
SUNDAY SHIFT

Pink-cheeked & gentle I’ve walked to work on this mellow roots-swelling, buds-bursting spring morning reading notes, signs, scents & sounds in the air.
I prepare to do room checks.
Always I scan the phone room, smoke room, group areas, washrooms, the kitchen gauging what might be found or hidden behind their not-private bedroom doors.
I learned quickly that here kitchen surfaces really are Rorschach assessment tools.
If there’s food on the floor, the counters are clumpy & crumbed, if there are spill-sticky spots, dirty dishes piled, burn on the stove’s dark spirals, grease on the whites of its centre, I can anticipate sour moods, anger, a cranky waking up.
When I knock on & unlock their doors I am sensitive & still feel somehow responsible when they hurt, crack or alcohol binge, damage themselves, disappear.
This particular morning three women greet me smiling easily (three senior Persian cats in the sun). Quietly they’re sharing recipes & advice about bread making. Three fresh loaves proudly displayed there on the counter.
White flags of truce & warm smell of victory over another dark night, temptations into regression, urges to punish each other, urges to accept punishment for things they’ve never done, never done to each other but which have been done onto them somewhere by someone.
Now they’re spreading calm ambiguity, an unexpected acceptance, butter, jam on loaves they’ve created themselves for each other and the others. All this kinda affirming human tenacity. All this possibility for recovery & discovery they share with me. (Transken, 2008b)

The fourth theme that appears implicitly in some articles and explicitly in others is criminalization of women’s drug use. The connections between the drug use, self harm, harm by others, and criminality are complex. The criminalization of drug use oftentimes increases the harms experienced by women who use drugs. One of the pillars of harm reduction recognized by the international community is reduced criminalization of drug misuse. Decriminalization redirects policing away from the illegal nature of drug use and toward connecting people with services to address their problematic drug use. As Bungay and colleagues (in this issue) point out, reduced criminalization intends to address the underlying issues contributing to urban women’s substance misuse.

Despite the considerable literature that points to the effectiveness of this pillar of harm reduction, Canada’s National Anti-drug Strategy is currently placing greater emphasis on law enforcement. This short-sighted approach to drug misuse as a crime rather than a public health problem punishes the individual and does little to address the complex social issues contributing to problematic drug use (Canadian HIV/AIDS Legal Network, 2008). It may be argued that the criminalization of drug use together with the constriction on public funding for health programs and services is having a disproportionately negative affect on substance-using women. This is particularly concerning for women living in smaller urban centres and rural locations. The Canadian Centre on Substance Abuse (2005) reports that the differences in drug use between urban and rural population are “generally small.” Similarly, a needs assessment of people injecting drugs in Newfoundland and Labrador revealed few differences between urban and rural residents (ACNL & HRU, 2007). In these rural and small urban settings, there are
varying levels of awareness and commitment to harm reduction strategies and limited funding for programs and services (Gustafson, Goodyear & Keough, 2008). Thus, specific female populations such as sex workers or those who inject drugs will be particularly hard pressed to find programs and services tailored to meet their needs and may instead be subject to policies that criminalize their behaviour.

If we agree that health is more than the state of wellbeing but rather a capacity or resource that enables people to manage their surroundings (Epp, 1986), then research that intends to protect and promote women’s health is concerned with building healthy communities and promoting healthy public policy. The contributors to this special issue, while focused outward on women who misuse substances, also told us something about themselves and others who care for and about these women. Therefore, we conclude with another poem that captures the four broad themes that frame this issue about urban women and problematic substance use: the political relevance of a gender-based approach to drug use; the importance of contextualizing the wide range of drug-related harms experienced by women; the value of community-driven and evidence informed harm reduction strategies; and persistent tension between harm reduction and criminalization of substance misuse.

QUARTERLY REPORT
Since January where’d they go?

Some have moved on somehow to somewhere
with or without tracks.
One’s gone—so gone for sure to a crack shack.
One’s installed in jail (this may save her life for another month).
One’s moved in with a John she’s sure she’s repulsed by –
but for sex, cooking, cleaning she’s got food, bruises, a roof over it all.
One’s in detox.
One’s been confiscated by her hateful sister; trapped as a nanny, obligated
to be grateful, available 24/7 and assigned a bed in the basement.
One’s in a mental health facility.
One’s in a tent by the river.
One’s in hospital ricocheting from uncured to incurable.
One’s gone searching to repatriate with her distant children.
One’s gone to reserve, her abusers, her myths.
One’s in a spiritual healing center.
One’s in a church’s philanthropic embrace.
One fell in love and it might work, this time.
Many are still here. Still.
Many are unknown in their whereabouts, where withal, wear and tear.
Two are in pauper’s coffins.
Everyone’s looking to fix or find their teeth.
May 1st: the streets are warmer if not friendlier. (Transken, 2008c)
REFERENCES


ACNL & HRU (AIDS Committee of Newfoundland & Labrador and Health Research Unit of Memorial University). (2007). Injection Drug Use in Newfoundland & Labrador. St. John’s, NL.


