

Title of PhD Program: **International PhD Program in Gender Studies**

Thesis title: **Drug use in Georgia from a Gender Perspective**

Name of Student: **Elene Japaridze**

Name, degree and positions of Academic Supervisor: **Professor Darja Zavirsek, Ph.D. Chair of the Department for Social Justice and Inclusion, President of the Eastern European Sub-Regional Association of the Schools of Social Work of the IASSW, Faculty of Social Work, University of Ljubljana**

Date, Institution: **Center for Social Sciences, 01.09.2014.**

Table of Contents

Acknowledgements	5
Abstract	6
Introduction	7
Chapter 1	10
Literature Review	
• Differences in drug use in Western societies—a comparative overview	10
• The stigmatization of individuals with drug use problems	11
• The attitudes of the medical staff and health care professionals towards people with drug use problems	20
• Reactions to stigma by people with drug use problems	23
• Negative effects of stigma on treatment and recovery of individuals with drug use problems ..	26
• Focusing on women with drug use problems and its implications from the gender perspective.....	29
• Conclusion.....	39
Chapter 2	42
Research Methodology	
• Preparatory work and study techniques	42
• Fieldwork	46
• Professionals in the drug rehabilitation field	46
• Qualitative research instrument: A discussion guide for in-depth interviews with respondents with drug use problems	50
• Individuals with drug use problems	52
• Stage I : Sampling process of women with drug use problems	54
• Recruiting of female respondents in Tbilisi	54
• Recruiting of female respondents in Gori and Zugdidi	61
• Stage II : Sampling process of men with drug use problems	66
• Recruiting of male respondents in Tbilisi	67

• Recruiting of male respondents in Gori and Zugdidi.....	69
• Analysis	72
Chapter 3	73
A Historical Review of Drug Related Affairs in Georgia	
• Introduction	73
• Georgia and drug use in the recent past	74
• Changes and challenges on the Georgian drug market	77
• Legislative changes and their weaknesses	81
• Sharpening of the drug use legislation in Georgia	82
• Current debates: effective planning of drug policy	89
• Stigma at the legislative level.....	91
• Opportunities and weaknesses of drug treatment in Georgia.....	92
• Conclusion	98
Chapter 4	101
Opinions of Georgian Drug Experts	
• Introduction	101
• Reasons for drug use	102
• The issue of stigma reflected by professional helpers	110
• Gendered treatment protocols	117
• Conclusion	123
Chapter 5	126
Men and Women with Drug Use Problems	
• Introduction	126
• Gender differences in the motivation and first use of illegal drugs	128
• The social stigma against individuals with drug use problems	142
• Stigma and women with drug use problems	151
• Conclusion	159

Chapter 6	159
Drug Treatment: Barriers and Solutions	
• Introduction	160
• Problems and barriers	161
• Women-oriented treatment services	172
• Conclusion and recommendation for successful model of treatment	183
Chapter 7	185
Conclusion	
Bibliography	190
Appendix 1	207
Appendix 2	209

Drug Use in Georgia from a Gender Perspective

Acknowledgements

It is my pleasure to acknowledge many people who have given me guidance, help, support and encouraged me during the four-year working process on my dissertation.

I would like to first thank Professor Darja Zavirsek for her constant guidance, personal attention and full support during last four years of my graduate study and research. I do enjoyed cooperation with Proffesor Zavirsek very much and would like to express my appreciation for many valuable ideas, suggestions, comments and discussions during our working process.

Special thanks go to Professor Joanna Regulska for many provoking questions and discussions.

Special thanks to Professor Marine Chitashvili for her support throughout the process of writing this paper and many valuable suggestions.

I would like to express my sincere appreciation to the whole CSS administration who gave me hands-on help in many aspects of this research program, and their caring and concern about this dissertation.

I will forever be thankful to the Open Society Georgia Foundation, who funded my research, without their financial support this dissertation would not have been accomplished.

My special appreciation goes to the experts working in the drug rehabilitation field who participated in my study - Ms Jana Javakhishvili, Mrs Marina Chavchanidze, Mrs Nino Janashia and Mrs Ketevan Bidzinashvili who supported me during my study, gave me much information and discussion in this respect.

I also thank my good friend and colleague Ms Mariam Amashukeli for her constant support, feedback and advice. Ms Amashukeli has been helpful in providing good advice, valuable critics and comments many times during my PhD career.

Finally, I would express my gratitude to my parents and my husband whose support and constant encouragement helped me to continue my work. My deepest appreciation is expressed to them for understanding and support.

Abstract

Historically, the studies addressing the issues of drug use and abuse focused mostly on men.¹ The study of the female population has faced difficulties because women have been underrepresented both in treatment services and in research as compared with men. Of course, women were added to samples, but no gender-related perspectives were used. For this reason, drug use by both women and men was viewed through a strictly male lens. In the 1980s, western studies began to place women and gender at center stage² and more scholars acknowledged the importance of challenging the conceptual framework in studying drug abuse and treatment issues.

From the late 90s the connection between violence, victimization and different treatment needs for women with substance use problems came to the forefront in these studies.³ However, in the case of Georgia the situation regarding gender biases in drug addiction issues continues to be neglected.

Adopting a gender and feminist perspective, this paper examines what social and cultural factors affect the behavior of men and women with drug dependence in Georgia; explores the different experiences of both genders, and highlights the significance of listening to women's needs, as well as the importance of provision of special treatment services for females with drug use problems.

Using qualitative research methods (52 in-depth interviews with individuals suffering from drug addiction and 20 interviews with drug rehabilitation experts), this dissertation paper demonstrates the gender discrimination and social injustice in the case of women who use drugs in Georgia. Unlike men, women suffering from drug addiction in Georgia are much more stigmatized, discriminated against and victimized, and face many more social as well as structural barriers while entering treatment than men. Women are considered to be in a more disadvantaged position because they have less autonomy and recognition. By listening to women, assessing their experiences and comparing them with those of men, this paper aims to raise awareness about women with substance abuse problems in Georgia and highlight the problems they deal with in society. As such, this paper is aimed at providing a useful

¹ Anderson, T. L. (2001). "Drug Use and Gender," *Encyclopedia of Criminology and Deviant Behavior, Vol. IV: Self-Destructive Behavior and Devalued Identity*, pp. 286-289.

²Rosenbaum, M. (1980). *Women on Heroin* New Brunswick, NJ: Rutgers University Press.

³Kaufman-Kantor, F. & Asdigian, L. (1997). "Gender differences in alcohol-related spousal aggression." In R. W. Wilsnack and S. C. Wilsnack (Eds.), "Gender and alcohol: Individual and social perspectives" (pp. 312-333). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

contribution towards enabling women to obtain female-oriented treatment options and also to help establish a system whereby substance abuse treatment is not focused solely on men.

Introduction

Motivation and the availability of illicit substances are two necessary preconditions for drug use⁴but they are not sufficient to explain the complex phenomena of drug addiction. Experts disagree regarding the critical factors that contribute to drug addiction. Proponents of medical explanations suggest that drug dependence is a chronic, often relapsing, brain disease that causes compulsive drug seeking and use, in spite of harmful consequences for the addicted individual and for those around him or her.⁵ In contrast to medical theories that posit drug dependence as a biological phenomenon,⁶ social theories such as the life-process model of addiction⁷ suggest that drug dependence is not a disease at all; rather it is a form of habitual pleasure-seeking and a system of self-preservation that can only be explained and understood in the context of social relations and experience. Social theorists differ in the explanatory weight they accord to cultural, social, and economic factors, however.⁸ Some authors construe drug use as deviant behavior rather than a disease,⁹ while others attribute drug use to conformist behavior.¹⁰ While some experts emphasize social relations, others focus on the importance of psychological factors such as stress, depression, fears, and feelings of internal conflict and discomfort as the motivation for drug use.¹¹ According to these scholars, drugs are a means for individual escape from the discomfort caused by stress.¹² Because drug-induced escape is temporary, an individual continues to use drugs and develops a dependence upon them. But these theories do not necessarily complement or contradict each other. They merely examine drug addiction from different angles and actually supplement rather than

⁴Goode, E. (1989). *Drugs in American Society*. New York: McGraw-Hill Publishing.

⁵National Institute on Drug Abuse (2011). "The Science of Drug Abuse and Addiction," Available at: <http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction>, Accessed: 9 09.2012.

⁶Koob, G.F., Le Moal, M. (2006). "Neurobiology of Addiction," *Elsevier Science & Tech*.

⁷Available at: http://en.wikipedia.org/wiki/Life-process_model_of_addiction, Accessed: 16. 04. 2013.

⁸Oetting, E.R. and Donnermeyer, J.F. (1998). "Primary Socialization Theory: The Etiology of Drug Use and Deviance. I" *Substance Use and Misuse*, 33(4), pp. 995-1026.

⁹ Kaplan, H. B. (1975). "Sequelae of Self-derogation: Predicting from a General Theory of Deviant Behavior." *Youth and Society*, 7, pp. 171-197.

¹⁰ Akers, R. L. (1998). *Social learning and social structure: A general theory of crime and deviance*. Boston, MA: Northeastern University Press.

¹¹ Stewart, S.H., Karp, J., Pihl, R.O., Peterson, R.A. (1997). "Anxiety, sensitivity and self-reported reasons for drug use." *Journal of Substance Abuse*, 9, pp. 223-240.

¹²NIDA Community Drug Alert Bulletin - Stress & Substance Abuse. Available at: <http://archives.drugabuse.gov/StressAlert/stressalert.html>, Accessed: 16.04. 2013.

contradict each other.¹³ Some theories, though not all, may share the scientific explanations offered on the basis of one particular theory. One way or another, it is important to understand what these explanations imply, so that we can clearly see what type of evidence proves or disproves it. Although many explanations of drug use are cast in gender-neutral terms, careful examination of literature reveals that gender plays a constitutive role in accounts of drug use and addiction and in discussions of appropriate strategies for treatment.

Prior to the 1980s, research on substance use focused mostly on men.¹⁴ The study of the female population has faced difficulties as a result of women having been underrepresented both in treatment services and in research as compared with men. Of course, women were added to samples, but no gender-related concepts were used. For this reason, drug use by both women and men was viewed through a strictly male lens. In the 1980s, studies began to place women and gender at center stage. For instance, authors like Marsha Rosenbaum (1980) stressed the significance of gender socialization in drug use and abuse and acknowledged the importance of challenging the conceptual framework in studying drug abuse and treatment issues.¹⁵ But changing the conceptual framework proved to be difficult and took quite a long time. At first the studies focused on the biological differences of women and stressed the fact that, unlike men, females with drug use problems developed different psychological and biological problems. Research revealed that in women the disease has a unique etiology; it develops differently, and requires different treatment.¹⁶ For instance, women often have different mental health problems and suffer from acute depression, anxiety, and low self-esteem.¹⁷ However, the studies and analyses of the problems that women with drug dependence face were not focused on the causes of depression and low self-esteem; these factors were seen from a gender and feminist point of view at a later time.

The studies carried out in the 80s highlighted many important issues in relation to female drug use and this fact cannot be disregarded, but it was only in the 90s that women's problems were examined from the gender and feminist point of view¹⁸ and it was emphasized that the problems and difficulties that

¹³Goode, E. (1989). *Drugs in American Society* New York: McGraw-Hill Publishing.

¹⁴ Anderson, T. L. (2001). "Drug Use and Gender," *Encyclopedia of Criminology and Deviant Behavior, Vol. IV: Self-Destructive Behavior and Devalued Identity*, pp. 286-289.

¹⁵Rosenbaum, M. (1980). *Women on Heroin*. New Brunswick, NJ: Rutgers University Press.

¹⁶ Reed, B. G. (1987). "Developing women-sensitive drug dependence treatment services: Why so difficult?" *Journal of Psychoactive Drugs*, 19, (2), pp. 151-164.

¹⁷Nelson-Zlupko, L., Kauffman, E., & Dore, M. M. (1995). "Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women," *Social Work*, 40 (1), pp. 45-54.

¹⁸ Measham, F. (2002). "Doing Gender-Doing Drugs: Conceptualizing the Gendering of Drugs Cultures," *Contemporary Drug Problems*, 29 (2), p. 335.

women face because of their drug dependence may be caused by social and structural circumstances rather than by their biological and psychological condition. For example, from the late 90s the connection between violence and female drug abuse came to the forefront and the studies conducted at the time confirm the fact that there is a very strong correlation between violence and female drug abuse.¹⁹ More studies found that women with substance use problems are more likely to be victims of domestic violence,²⁰ are often socially isolated, and suffer from anxiety and depression.²¹ Many studies have evaluated a possible connection between childhood abuse and substance abuse and that the abuse history appears to be a significant risk factor for later drug addiction.²² Many researchers started talking about the need for different treatment services for women and considered that the reason for ineffective treatment may be the flawed treatment process rather than women's biological or social condition.²³

When studying drug use from the gender and feminist perspective, I think it is important to examine substance use more carefully and recognize the impact of social and cultural constructions of masculinity and femininity on individual and group use of drugs. Analyzing drug addiction through a gender lens enables us to see how males and females with drug use problems are differently perceived by society, and how different the problems and barriers are that they face because of their gender during drug use and treatment.

The theoretical framework that I have chosen for analyzing my thesis study is a feminist framework and the reason behind choosing this perspective is the desire to make people more aware of the reality that women face in everyday life and to make them see gender discrimination and social injustice in the cases of women who use drugs.²⁴ Studies conducted by feminists suggest that, unlike men, women have more mental health problems because there are many social and cultural factors that affect their lives.²⁵ Women are considered to be in a more disadvantaged position because they have less control and

¹⁹Kaufman-Kantor, F. & Asdigian, L. (1997). "Gender differences in alcohol-related spousal aggression." In R. W. Wilsnack, & S. C. Wilsnack (Eds.), "Gender and alcohol: Individual and social perspectives" (pp. 312-333). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

²⁰Ibid.

²¹ Greenfield, S. F. (2002). "Women and alcohol use disorders." Harvard Review of Psychiatry, 10 (2), pp.76-85.

²²Bennet, E. M., & Kemper, K. J. (1994). "Is abuse during childhood a risk factor for developing substance abuse problems as an adult?" *Developmental and Behavioral Pediatrics*, 15 (6), pp.426-429.

²³Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). "Effectiveness of substance abuse treatment programming for women: a review," *American Journal of Drug and Alcohol Abuse*, 29, pp. 19-35.

²⁴ Avis, J. M. (1988). *Deepening awareness: A private study guide to feminism and family therapy*. In L. Braverman (Ed.), *Women, feminism, and family therapy* (pp. 15-46). New York: Haworth Press.

²⁵Ibid.

influence over many life situations than men do. Based on a gender and feminist perspective, this paper examines what social and cultural factors affect the behavior of men and women with drug dependence in Georgia; explores the different experiences of both genders and highlights the significance of listening to women's needs, as well as the importance of special treatment services for females with drug use problems. This study reveals the need for treatment options tailored specifically for females. By listening to women, assessing their experiences and comparing them with those of men, this paper aims to raise awareness about women with substance abuse problems in Georgia and to highlight the problems they face in society. As such, this paper is constructed with the aim of providing assistance to women in obtaining gender-specific treatment options and in order to help establish a system whereby substance abuse treatment is not focused solely on men.

Chapter 1

Literature Review

Differences in drug use in Western societies –a comparative overview

As a researcher working on gender and women's issues, I was, first of all, very interested in finding a more in-depth explanation of gender differences in the addiction problems of males and females who use illicit substances. My main motivation during the search for literature was to explore: a) how individuals with drug use problems are perceived and treated by society; b) what kind of problems and difficulties individuals with drug use problems face; b) whether there is a gender difference in social and psychological barriers that individuals with drug use problems encounter; c) whether females with drug use problems have different treatment needs; and d) if there are gender differences in the above issues, how these differences can be explained.

To answer these questions, I decided to divide the chapter of literature review into two parts. In the first part, I present a review of various studies that show the most visible problem of individuals with drug dependence is stigma and stigmatized identity. To shed more light on the meaning of stigma and its consequences on an individual's health and daily life, the theory of stigma will be presented.

The second part of this chapter contains data from different studies about gender accounts in drug use and provides information about the characteristics, problems, and treatment needs of women who use illicit substances. The second part makes it clear that stigma and violence play a significant role in

female drug dependence complications and that stigma and violence are those factors where the differences between men and women are most prominent.

The stigmatization of individuals with drug use problems

Individuals with drug dependence are often stigmatized and rejected by society. If we come to understand the stigma attached to people who use drugs it will be easier to realize what men and women with dependence problems experience and what challenges and barriers they face in everyday life.

Stigma, as a term, is derived from Greek and once referred to a brand (a type of mark) that was cut or burned into the skin of criminals, slaves, or traitors in order to visibly identify them as blemished or morally polluted persons. As Crocker, Major, and Steele (1998) explain, a person who is stigmatized is devalued and spoiled.²⁶

German sociologist Gerhard Falk explained that the problem of stigmatization exists in every society, because stigmatization provides a delineation of ‘outsiders’ from ‘insiders.’²⁷ According to Falk (2001), there are two categories of stigma – existential stigma and achieved stigma.²⁸ Existential stigma is a ‘stigma deriving from a condition which the target of the stigma either did not cause or over which he has little control.’ By achieved stigma, Falk (2001) means a stigma ‘that is earned because of conduct and/or because they contributed heavily to attaining the stigma in question.’²⁹ However, the most influential work regarding the nature of stigma is the book *Stigma: Notes on the Management of a Spoiled Identity*, which was written by Erving Goffman in 1963.³⁰

Goffman (1963) defines stigma as an attribute, behavior, or reputation which is socially discrediting and is caused by one’s ‘undesired differentness.’ To be stigmatized means to be held in contempt,

²⁶ Crocker J, Major B, Steele C. 1998. “*Social stigma*.” Handbook of Social Psychology, vol. 2, pp. 504–53. Boston, MA: McGraw-Hill.

²⁷ Falk, G. (2001). “*Stigma: How We Treat Outsiders*.” Prometheus Books.

²⁸ Information obtained from: http://en.wikipedia.org/wiki/Social_stigma#Gerhard_Falk, Accessed: 4.10.2013.

²⁹ Falk, G. (2001). “*Stigma: How We Treat Outsiders*.” Prometheus Books.

³⁰ Goffman, E. (1963). “*Stigma: Notes on the Management of a Spoiled Identity*.” Englewood Cliffs: Prentice-Hall, Inc.

shunned, or rendered socially invisible because of a socially disapproved of status.³¹ Goffman (1963) argues that:

Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories ... When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his 'social identity' ... We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands ... It is [when an active question arises as to whether these demands will be filled] that we are likely to realize that all along we had been making certain assumptions as to what the individual before us ought to be. [These assumed demands and the character we impute to the individual will be called] 'virtual social identity.' The category and attributes he could in fact be proved to possess will be called his 'actual social identity.' While a stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive ... It constitutes a special discrepancy between virtual and actual social identity. Note that there are other types of [such] discrepancy ... for example, the kind that causes us to reclassify an individual from one socially anticipated category to a different but equally well-anticipated one, and the kind that causes us to alter our estimation of the individual upward.³²

According to Goffman (1963), stigmatized people are those who do not have full social acceptance and who have an attribute that is 'deeply discrediting.'³³ Crocker et al. (1998) explained that stigmatization occurs when a person has 'some attribute or characteristic that conveys a social identity that is devalued in a particular social context.'³⁴ What these definitions have in common is that they consider stigmatized people to be the individuals who have, or are thought to have, an attribute that sets them apart from others and this results in their debasement.³⁵

³¹Ibid.

³²Ibid., pp. 2-3.

³³ Goffman, E. (1963). "*Stigma: Notes on the Management of a Spoiled Identity.*" Englewood Cliffs: Prentice-Hall, Inc., p. 3.

³⁴ Crocker J, Major B, Steele C. (1998). "*Social stigma.*" Handbook of Social Psychology, vol. 2, p. 506,.Boston, MA: McGraw-Hill

³⁵Ibid.

As Shure (1971) explains, this attribute is something which deviates from what society has deemed 'normal.'³⁶ This attribute can be a physical mark or a behavior.³⁷ Stigmatized people, who are mostly individuals with physical and/or mental disabilities, sex workers, individuals with drug dependence problems, former prisoners, etc., need to battle permanently to adjust their social identities. Goffman (1963) draws a line between three types of stigma. Stigma which is mostly attributed to those individuals who are perceived to have weak will or are characterized with unnatural passions, unstable beliefs, and dishonesty is the *stigma of character traits*. Another type of stigma which refers to physical deformities of the body is *physical stigma*. The third type of stigma refers to *group identity* and derives from being of a particular race, nation, religion, etc. These stigmas are transmitted through lineages and contaminate all members of a family. All these types of stigma have the same sociological features: 'An individual who might have been received easily in normal social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us.'³⁸

In addition, Goffman (1963) makes a distinction between stigmatized people who are *discredited* and those who are *discreditable*. The stigma of the discredited is visible and obvious, interfering with an individual's everyday life. Because this stigma is visible, the stigmatized individual must focus on tension management and try to control social interactions between him/her and those who are accepted as 'the normals.' 'The normals,' according to Goffman (1963), are those who are not stigmatized and who belong to the non-stigmatized group.³⁹ Tactics of tension management include 'using levity to make light of one's stigma, appearance manipulation, and the careful following of a sometimes elaborate 'disclosure etiquette.'⁴⁰ But as Xavier (1999) writes in her analytic review of Goffman's work, 'The acceptance by 'the normals' of 'the discredited' gained by these strategies is always limited. Pushing for greater acceptance – equality with 'the normals' – breaks the commonly-accepted and well-understood rules of the game, with its reward of limited social tolerance. Thus, these 'discredited' become labeled by 'the normals' as "troublemakers," "militants," or "maladjusted" by

³⁶ Schur, E. M. (1971). *Labeling Deviant Behavior: Its Sociological Implications*. New York: Harper & Row, Publishers, p. 24.

³⁷ Goffman, E. (1963). *Stigma: Notes on the Management of a Spoiled Identity*. Englewood Cliffs: Prentice-Hall, Inc.

³⁸ Ibid., p.15.

³⁹ Ibid.

⁴⁰ Xavier, J. (1999). "Passing as Stigma Management – An Analytic Review of Stigma: Notes on the Management of Spoiled Identity by Erving Goffman." Available at:

http://learningtrans.files.wordpress.com/2010/11/jxavier_passing_as_stigma_management.pdf, Accessed: 18.08.2013.

psychotherapists, for their unwillingness to play their proper roles. Better put, they are condemned for their failure to remain well-behaved accomplices to their own marginalization and oppression.⁴¹

The stigma of the *discreditable*, which is not visible, gives an opportunity to develop some coping strategies and to pass as a member of the non-stigmatized group. However, Goffman (1963) explains that passing as a member of the non-stigmatized group imposes a high psychological price – a high level of anxiety – in living a life that can collapse at any moment.⁴² Goffman (1963) explains that a stigma not only affects the individuals who are stigmatized, but also those who are in close association with individuals and groups that are stigmatized. He introduces the concept of ‘courtesy stigma’ which is a prejudice towards people who are close to those who are stigmatized (for instance, family members, parents, relatives, and friends). Thus, the wife of an individual with mental disorders can be stigmatized simply because of the association with her husband’s illness.

Goffman (1963) writes that ‘The problems faced by stigmatized persons spread out in waves of diminishing intensity among those they come in contact with.’⁴³ He describes the individuals affected by ‘courtesy stigma’ as persons who are normal, ‘but whose special situation has made them intimately privy to the secret life of the stigmatized.’⁴⁴ The author calls them ‘wise’ and states that because these individuals accept the stigmatized people, this fact ‘confronts others with too much morality.’⁴⁵

Central to any discussion of stigma is the powerful influence it exerts on a person’s identity.⁴⁶ Goffman (1963) makes a distinction between social, personal, and ego identity. He explains social identity as a construct of stereotypes, assumptions, and relationships that concern society’s expectations of the individual. Personal identity, according to Goffman (1963), is a construct of biographical and personal data, and ego identity is the subjective sense of situation, continuity, and character as it is felt by the individual. In the case of stigma, the ego identity is responsible for what and how the individual feels about stigma and its management.

Goffman (1963) divides the individual’s social world into two groups – the ‘In-Group’ and ‘Out-Group.’ He calls individuals belonging to the ‘In-Group’ ‘us’ and those who belong to the ‘Out-

⁴¹Ibid.

⁴² Ibid.

⁴³Goffman, E. (1963). “*Stigma: Notes on the Management of a Spoiled Identity.*” Englewood Cliffs: Prentice-Hall, Inc., p. 3.

⁴⁴Goffman, E. (1963). “*Stigma: Notes on the Management of a Spoiled Identity.*” Englewood Cliffs: Prentice-Hall, Inc., p. 28.

⁴⁵Ibid., p. 30.

⁴⁶ Lemert, E. M. (1951). “*Social Pathology: A Systematic Approach to the Theory of Sociopathic Behavior.*” New York: McGraw-Hill.

Group’ - ‘them.’ Goffman explains that the stigmatized individual strives to find a place in both of these groups, though often he/she does not belong to either. Goffman (1963) understands well that people cannot be divided into the stigmatized and the normal, because people often experience both roles simultaneously, due to the fact that the set of attributes that are stigmatized changes over time.

Jones et al. (1984) said that stigma had six ‘dimensions:’ 1) how a person can hide the attribute or behavior that leads to stigma; 2) the consequences of such attribute or behavior in the long run; 3) how the attribute prevents a person from carrying out his/her daily activities; 4) what a person with the stigmatizing attribute looks like; 5) to what extent the person is responsible for his/her attribute/behavior; and 6) the level of threat posed by such attribute/behavior to others.⁴⁷ Similarly to Goffman (1963), Jones et al. (1984) also understands that different cultures and individuals have different stigmas and suggests that while one person may find a particular behavior demeaning another person may consider the same behavior as charming.⁴⁸ Moreover, Jones et al. (1984) state that most of us have experienced both sides of the stigmatizing relationship – being in a situation where people around us react negatively to our ethnic, racial background, gender, weight, etc. and most of us have also reacted to other people’s stigmas.⁴⁹ The stigma can be a physical ‘mark,’ or a non-standard behavior suggesting that the person may be abusing drugs or alcohol.⁵⁰ Jones et al. (1984) acknowledge that the degree of responsibility of a person in putting himself/herself in a stigmatized position is also very important.⁵¹ The stigma is harsher against those individuals who are believed to be responsible for drawing stigma upon themselves. Individuals who use drugs are those who most often face the above problem. Although addiction is regarded as a medical condition,⁵² it might seem that treating it as a disease is a protection against stigma.⁵³ However, such assumption proved to be false. The following sub-chapter will focus on the level and intensity of stigma towards individuals with drug use problems.

⁴⁷ Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., Scott, R. (1984). “*Social Stigma: The Psychology of Marked Relationships.*” New York: W.H. Freeman & Company; 1st Edition, p. 24.

⁴⁸ *Ibid.*, p. 5.

⁴⁹ Lloyd, C. (2010). “Sinning and Sinned Against: The Stigmatization of Problem Drug Users.” Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf> Accessed: 14.08.2013.

⁵⁰ Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., Scott, R. (1984). “*Social Stigma: The Psychology of Marked Relationships.*” New York: W.H. Freeman & Company; 1st Edition, p. 8.

⁵¹ *Ibid.*, p. 56.

⁵² Acker, C. J. (1993). “Stigma or Legitimation? A Historical Examination of the Social Potentials of Addiction Disease Models,” *Journal of Psychoactive Drugs*, 25(3), pp. 193-205.

⁵³ Center for Addiction and Mental Health (1999). “The Stigma of Substance Use: A Review of the Literature.” Available at: http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_sub_abuse_litreview99.pdf, Accessed: 8.08.2013.

According to various studies, the burden of stigma varies according to different countries but in western societies it is the heaviest for disabled people, ethnic minorities, mentally ill people, as well as those abusing drugs and alcohol.⁵⁴ Most researchers agree that something needs to be done to change this situation as stigma is negative; however, it is clear that stigmatized individuals find it very difficult to dispose of the stigma, because it tends to stick for an extended period of time.⁵⁵ Goode (1984) stated that society has done nothing to counteract the stigmas imposed by it.⁵⁶

There are some strategies for individuals to cope with the status of deviance and/or stigma in a number of ways, and history provides clear evidence that various groups of stigmatized individuals have managed to minimize the stigma by changing social attitudes.⁵⁷ Groups that were previously seen as 'deviant' include gays and lesbians, divorced persons, disabled persons, African Americans, etc.⁵⁸ As noted in *The Stigma of Substance Use: A Review of the Literature*, some of the most successful 'destigmatization' strategies shifted the discourse from deviance and stigma to human rights.⁵⁹ However, it is understood that the process of coping with stigma and neutralizing the deviant status is very complex and involves a lot of changes in social attitudes.⁶⁰ The positive outcome depends on whether stigmatized groups and individuals are seen as being responsible for their stigma and are blamed for deviation from socially accepted norms. Therefore, those individuals who are judged to be responsible for their deviant behavior experience a much higher level of stigmatization from society than others who are not blamed.

Judgment and blame for attaining a stigmatized label is most frequent in the case of individuals with drug use problems. Most people have no sympathy for individuals who use drugs, believing that drug use is a self-inflicted problem. Such public opinion is based on the ideology that those who use drugs have an option of not using them. The same sentiments are echoed by Roberts (2009) who studied the

⁵⁴ Lloyd, C. (2010). "Sinning and Sinned Against: The Stigmatization of Problem Drug Users." Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed: 14.08.2013.

⁵⁵ Goode, E. (1984). *"Deviant Behavior"* (Second Edition). Englewood Cliffs: Prentice-Hall, Inc., p. 35.

⁵⁶ Ibid.

⁵⁷ Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., Scott, R. (1984). *"Social Stigma: The Psychology of Marked Relationships."* New York: W.H. Freeman & Company; 1st Edition, p. 306.

⁵⁸ Center for Addiction and Mental Health (1999). "The Stigma of Substance Use: A Review of the Literature," Available at: http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_sub_abuse_litreview99.pdf, Accessed: 8.08.2013.

⁵⁹ Ibid.

⁶⁰ Ben-Yehuda, N. (1990). *"The Politics and Morality of Deviance: Moral Panics, Drug Abuse and Reversed Stigmatization."* Albany: State University of New York Press, pp. 66-67.

public opinion of individuals with drug use problems and found out that ‘35 percent of respondents agreed with the proposition that drug addiction was always the individual’s fault.’⁶¹

Individuals with drug use problems are normally discriminated against and viewed as outcasts with no moral position in society. Such public opinion has led to increased stigmatization of these individuals. As noted in the Scottish Social Attitudes Survey (2009), ‘When asked about possible contact with heroin users (or ex-heroin users), people who are in work appeared more comfortable with the idea of working with a former addict than did people in general about a recovering drug user moving to a house or flat near them.’ This is the reason why the general public does not want to associate with individuals who use or have used drugs. They view them as outcasts with no moral values or position in society.⁶²

As noted by Roberts (2003), most government institutions have propagated the ideology that individuals addicted to drugs are dangerous people and threaten peaceful co-existence in society. This is caused by the fact that most people who use drugs are normally categorized as high risk individuals and are normally incarcerated in drug rehabilitation centers with stringent punitive measures. According to Roberts (2003), ‘Overzealous punishment in the form of prison sentences for drug users is also inconsistent with global trends.’ Roberts (2003) gives the example of the United States where ‘the rate of imprisonment has not changed over the past decade. Fourteen percent of persons convicted of unlawful production and approximately half of those charged with unlawful supply or possession with the intent to supply were sentenced to prison.’⁶³ This has shaped the public opinion about individuals with drug use problems in the sense that the public views them as high-risk individuals who are a drain on society, and are criminals. The same sentiments are echoed by Taylor (2008) who points out that ‘The ramifications of such representations are that users of heroin and crack cocaine are thought of as risk-bearing “outsiders” and are actively excluded from society.’⁶⁴ These individuals are seen as both blameworthy and to be feared. As a result, they are subject to exclusion and discrimination in many areas, which leads to serious negative consequences. As noted by the UK Drug Policy Commission (2010), the stigmatization of people with drug problems has serious consequences for

⁶¹Roberts, J. V. (2003). *Penal Populism and Public Opinion: Lessons from Five Countries.* Oxford: Oxford University Press.

⁶²Scottish Social Attitudes Survey (2009). Available at: <http://www.scotland.gov.uk/Publications/2010/05/19111419/0>, Accessed: 9.10.2013.

⁶³ Roberts, J. V. (2003). *Penal Populism and Public Opinion: Lessons from Five Countries.* Oxford: Oxford University Press.

⁶⁴Taylor, S. (2008). “Outside the Outsiders: Media Representations of Drug Use”, *Probation Journal*, 55940, pp. 369-387.

government policy, they are rejected by communities, family members and wider society and are seen as deviants (evil, thieving, dirty, dangerous, etc.), which impedes the recovery that society wishes to promote.⁶⁵ Another good example of the negative effect of stigmatization on people with substance use problems is demonstrated by Link et al. (1997). These scholars conducted a study among men with a dual diagnosis of mental illness and substance abuse and found out that, because of the expectations and experiences of rejection, people who are stigmatized due to a mental illness and/or drug use develop specific coping strategies like ‘secrecy’ and ‘withdrawal.’⁶⁶

An excellent review of various studies regarding stigma and its consequences on individuals with drug use problems is offered by Charlie Lloyd (2010). In the paper *Sinning and Sinned Against: The Stigmatization of Problem Drug Users*, Lloyd (2010) discusses several UK and US studies and presents a comprehensive and clear picture of how negatively the public is predisposed towards people who use drugs.⁶⁷ For example, Lloyd (2010) reviews a study undertaken by the Office for National Statistics on behalf of the Royal College which included questions on attitudes to drug addiction in both the 1998 and 2003 surveys.⁶⁸ The above-mentioned study demonstrated that individuals with drug use problems were thought to be more dangerous, unpredictable, hard to talk with, and blameworthy for their condition.⁶⁹

Another interesting piece of research mentioned in Lloyd’s (2010) paper is a study by Luty and Grewal (2002) which showed that while 28 percent of respondents regarded most drug-dependent individuals as having a mental illness, 38 percent regarded them as criminals. Seventy-eight characterized them as ‘deceitful and unreliable,’ and 62 thought that the law was too soft on them.⁷⁰

⁶⁵UK Drug Policy Commission (2010). “Getting Serious about Stigma: The Problem with Stigmatizing Drug Users.” Available: http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf, Accessed at: 9.10.2013.

⁶⁶Link, B. G., Struening, E.L., Rahav, M., Phelan, J.C., Nuttbrock.L. (1997). “On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with a Dual Diagnosis of Mental Illness and Substance Abuse.” *Journal of Health and Social Behavior*, 38 (1), p. 180.

⁶⁷ Lloyd, C. (2010). “Sinning and Sinned Against: The Stigmatization of Problem Drug Users” Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed: 14.08.2013.

⁶⁸Crisp, A., Gelder, M., Goddard, E., Meltzer, H. (2005). “Stigmatization of people with mental illness: A follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists,” *World Psychiatry*, 4 (2), pp. 106-113.

⁶⁹ Lloyd, C. (2010). “Sinning and Sinned Against: The Stigmatization of Problem Drug Users”. Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf> Accessed: 14.08.2013.

⁷⁰ Ibid.

Other studies undertaken in the US that were reviewed by Lloyd (2010) also confirm the greater stigmatization towards drug addiction in comparison with mental illnesses⁷¹ and show how stigma extends to other members of the family.⁷² For example, a study conducted by Corrigan et al. (2009) showed that the families of drug-dependent people were the most stigmatized; they were being viewed as almost responsible for the person originally getting ‘ill’ and most likely to be at fault should the person relapse.⁷³ This study clearly showed the above-mentioned problem related to ‘courtesy stigma’ which was explained by Goffman (1963) as a stigma towards those individuals who are in close association with those who are stigmatized.

A study undertaken by Bryan et al. (2000), *Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Survey*, also demonstrates the high level of social avoidance and fear of ‘addicts’ and shows that over half of the respondents believe that those with a drug problem have only themselves to blame.⁷⁴

The report entitled *Stigma, Discrimination and Substance Use: Experiences of People Who Use Alcohol and Other Drugs in Toronto* shows that people who use alcohol/other drugs in Toronto experience stigma and discrimination in all aspects of their lives, which has a significant impact on their self-esteem, health, well-being and access to health and social services, housing, education and employment opportunities.⁷⁵

The negative attitudes of society towards individuals with drug use problems are not surprising, because the studies make it visible that in most societies drug use is still regarded more as an offence than a health care problem and the law on the drug policy provides for both punishment and prosecution for such behavior.⁷⁶ The media perception of individuals with drug use is another important aspect to consider. Such individuals are represented as criminals, ghetto dwellers, hustlers,

⁷¹Corrigan, P.W., Kuwabara, S.A., O’Shaughnessy, J. (2009). “The Public Stigma of Mental Illness and Drug Addiction: Findings from a Stratified Random Sample”, *Journal of Social Work*, 9 (2), pp. 139-47.

⁷²Corrigan, P.W. and Shapiro, J.R. (2006). “Blame, Shame, and Contamination: The Impact of Mental Illness and Drug Dependence Stigma on Family Members”, *Journal of Family Psychology* 20 (2), pp. 239-46.

⁷³ Lloyd, C. (2010). “Sinning and Sinned Against: The Stigmatization of Problem Drug Users”. Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf> Accessed: 14.08.2013.

⁷⁴Bryan, A., Moran, R., Farrell, E., O’Brien, M. (2000). “Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Survey”, Dublin: The Health Research Board.

⁷⁵Toronto Drug Strategy Implementation Panel (2010). “Stigma, Discrimination and Substance Use: Experiences of People Who Use Alcohol and Other Drugs in Toronto”. Available at: <http://www.toronto.ca/health/drugstrategy> Accessed: 10.08.2013.

⁷⁶UK Drug Policy Commission (2010). “Getting Serious about Stigma: The Problem with Stigmatizing Drug Users”. Available at: http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf Accessed: 9.10.2013.

and thieves. According to the UK Drug Policy Commission (2010), in the recent past the media has presented a negative impression of individuals with drug use problems, which marginalizes and demonizes them. The UK Drug Policy Commission (2010) notes that ‘nearly two-thirds (64percent) of adults in the UK agreed with the statement that people with a history of drug dependence are too often demonized in the media.’⁷⁷ Hence, society receives a negative and diminishing message about people who use drugs, and this information contributes to the creation of stigma and discriminating attitudes towards them. As noted by Ettore (2004), ‘Hegemonic’ moral panics are generated by the media to remind the general population of the deviance of drug users’ and to separate these “deviants” from the mainstream.’⁷⁸

The attitudes of medical staff and healthcare professionals towards people with drug use problems

When conducting the literature review, I was surprised to discover that medical staff and healthcare professionals working with individuals with drug use problems often hold negative and discriminatory attitudes towards such individuals. Individuals with a medical education are expected to be more tolerant towards those who have substance dependence problems as medical education is supposed to ensure a more in-depth understanding of the nature of addiction. However, studies comparing attitudes of healthcare workers towards people with diverse medical and mental health conditions indicate that physicians are characterized with the most severe judgments and the highest rate of rejection of people with substance use problems.⁷⁹

According to Merrill et al. (2002), caring for patients who are considered to be active drug users by healthcare professionals can be a daunting process fraught with disappointment.⁸⁰ Merrill et al. (2002) state that physicians fear the chance of being deceived by patients with drug use problems and have doubts that patients' requests for opiates to treat pain or withdrawal may result from addictive behavior rather than from a ‘medically induced’ need. As a result, such interaction between physicians and

⁷⁷Ibid.

⁷⁸ Ettore, E. (2004). “Revisioning Women and Drug Use: Gender Sensitivity, Embodiment and Reducing Harm.” Available: <http://www.medanthro.net/adtsq/wp-content/uploads/2012/12/Ettore-Revisioning-Women-+-Drug-Use.pdf>, Accessed: 8.10.2013.

⁷⁹Toronto Drug Strategy Implementation Panel (2010). “Stigma, Discrimination and Substance Use: Experiences of People Who Use Alcohol and Other Drugs in Toronto.” Available at: <http://www.toronto.ca/health/drugstrategy>, Accessed: 10.08.2013.

⁸⁰Merrill, J.O., Rhodes, L.A., Deyo, R.A., Marlatt, G.A., Bradley, K.A. (2002). “Mutual Mistrust in the Medical Care of Drug Users,” *Journal of General Internal Medicine*, 17(5), pp. 327-333.

patients with drug use problems has led to mistrust between the two groups. The end result is even more harmful in the sense that, due to mistrust, physicians are not able to meet the genuine demands of such individuals. In some cases, as Beaumont (2004) posits, the interaction can eventually lead to mistreatment of individuals with drug use problems by healthcare professionals.⁸¹

Several studies reviewed by Lloyd (2010) also demonstrate that healthcare staff exhibit a high level of stigma and offer inappropriate service to people with drug use complications. Studies conducted by McLaughlin and Long (1996) in the 1980s and 1990s, which Lloyd (2010) discusses in his paper, show that the majority of healthcare professionals hold negative, stereotypical perceptions of people who use illicit drugs and that the prejudice among nurses prevents them from providing ‘effective and humane nursing care’ for people with drug use problems.⁸²

In some instances, individuals with drug use problems are denied access to various treatments, including treatment for HIV and hepatitis. The Eurasian Harm Reduction Network notes that, prior to 2004, in Russia and some other countries individuals with drug dependence who were deemed to lack ‘social prospects’ were systematically denied access to HIV treatment.⁸³ Beaumont (2004) argues that in some cases such individuals are even denied access to various pain intervention and management options.⁸⁴ According to Beaumont (2004), doctors and healthcare professionals normally address individuals with drug use problems with harsh, unfriendly, and derogatory language.⁸⁵

The same sentiments are expressed by Loenieke et al. (2013). In their study, these scholars sought to investigate the stigma among various healthcare professionals towards patients with drug use disorders and the various consequences of stigma for the provision of healthcare services. As noted by Loenieke et al. (2013), healthcare professionals generally hold negative attitudes towards patients with substance use disorders and consider violence and low motivation as preventing factors in healthcare delivery for them.⁸⁶ Beaumont (2004) also notes that most healthcare professionals view individuals with drug use problems as people who have no value in society and who do not consider their health condition as

⁸¹ Beaumont, B. (2004). *Care of Drug Users in General Practice: A Harm Reduction Approach.* Oxford: Radcliffe Pub.

⁸² McLaughlin, D. and Long, A. (1996). “An Extended Literature Review of Health Professionals’ Perceptions of Illicit Drugs and Their Clients Who Use Them,” *Journal of Psychiatry, Mental Health and Nursing*, 3 (5), p. 283.

⁸³ Eurasian Harm Reduction Network. “Stigma and Discrimination,” Available at: <http://www.harm-reduction.org/stigma-discrimination.html>, Accessed: 5.12.2013.

⁸⁴ Beaumont, B. (2004). *Care of Drug Users in General Practice: A Harm Reduction Approach.* Oxford: Radcliffe Pub.

⁸⁵ Ibid.

⁸⁶ Loenieke, C., Van, B., Evelien, P.M., Jaap, V.W., Henk, F.L.G. (2013). “Stigma among Health Professionals towards Patients with Substance Use Disorders and Its Consequences for Health Care Delivery: Systematic Review,” *Drug and Alcohol Dependence*, 131 (1), pp. 23-35.

being of any vital significance. This has escalated the discrimination of such individuals among healthcare professionals.⁸⁷ In this case, we encounter a serious problem because the discrimination of individuals with drug use problems leads to their stigmatization in the sense that the people best owed with the mandate of taking care of these individuals are the ones who escalate their stigmatization. Similar sentiments are echoed by Ronzani et al. (2013) who investigated the stigmatization of users of alcohol and other drugs by various primary care providers in the southeast region of Brazil.⁸⁸ According to these scholars, nursing assistants and community healthcare workers displayed the severest judgment of alcohol use. Moreover, those individuals who were addicted to marijuana/cocaine suffered the highest rate of rejection by professionals. Ronzani et al. (2013) confirmed the hypothesis that the use of alcohol and other drugs is heavily stigmatized by healthcare professionals. The scholars recommend that it is important to develop new strategies to change provider attitudes in order to ensure a higher quality of service for patients with drug use problems.⁸⁹

One conclusion we can draw on the basis of reviewing the attitudes of healthcare professionals towards individuals with drug use problems is that such individuals can be very difficult to deal with in a treatment setting. Stigma may be one of the main reasons for the low proportion of individuals with addiction in treatment.⁹⁰ This might result from a number of factors, including the desire of the individuals to avoid the label of addict, a fear of being seen by other people who attend treatment services, and fears about employers finding out about their addiction, as well as previous negative experiences with health care.

A further point, referred to above, is that while the attitudes and responses of medical staff in these settings seem to be shaped by their regular interactions with individuals with substance use problems, it should not be forgotten that they are also likely to be influenced by some of the beliefs and assumptions about such individuals that are prevalent in wider society. Experience, knowledge, and expertise do not make one immune to wider social influences.⁹¹

⁸⁷ Beaumont, B. (2004). *Care of Drug Users in General Practice: A Harm Reduction Approach.* Oxford: Radcliffe Pub.

⁸⁸ Ronzani, M.T., Higgins-Biddle, J., Furtado, F.E. (2013). "Stigmatization of Alcohol and Other Drug Users by Primary Care Providers in Southeast Brazil." *Social Science & Medicine*, 69(7), pp. 1080-1084.

⁸⁹ Ibid.

⁹⁰ Kelly, J.F. and Westerhoff, C.M. (2010). "Does it Matter How We Refer to Individuals with Substance-Related Conditions?" A randomized study of two commonly used terms, *International Journal of Drug Policy*, 21 (3), pp. 202-7.

⁹¹ Lloyd, C. (2010). "Sinning and Sinned Against: The Stigmatization of Problem Drug Users." Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed: 14.08.2013.

Reactions to stigma by people with drug use problems

Research demonstrates that most individuals with drug use problems experience a very severe stigma from society and suffer from a broad range of social, psychological, and health-related problems.⁹² Studies confirm that stigmatizing attitudes of other people can have a negative impact on the lives and health conditions of users of illicit substances. As Goffman (1963) explains, stigmatized individuals accept the ‘normal’ world view, and a stigma or mark may form an important part of their sense of self.⁹³ And when ‘a mark becomes a central point of the self-concept then the stigmatizing process is engaged.’⁹⁴ It is the stigmatizing attitude of society and health professionals that often leads individuals with drug use problems to feelings of low self-worth and avoidance of treatment and rehabilitation.⁹⁵

A strong desire to avoid the label of addict, a fear of being recognized by other people attending treatment services, and negative experiences with healthcare staff may complicate the daily lives and health condition of individuals with drug use problems.⁹⁶ However, there are various strategies that such individuals employ to cope with the stigma they face in society.

One such approach is the spirituality strategy. In order to cope with stigmatization effectively, most individuals with drug dependence resort to spirituality to obtain some form of moral encouragement.⁹⁷

Another stigma-coping strategy that individuals with drug use problems utilize is the secrecy and withdrawal strategy. Stigmatization of substance use has created a public image that those who use drugs should be discriminated against and that they are criminals characterized with immoral and socially unacceptable vices. To deal with such a level of stigmatization, a number of individuals with drug problems resort to secrecy and withdrawal as stigma coping strategies. The secrecy and

⁹²Miller, P.G. and Miller, W.R. (2009). “What Should We Be Aiming for in the Treatment of Addiction?” *Addiction*, 104 (5), pp. 685-6.

⁹³Goffman, E. (1963). “*Stigma: Notes on the Management of a Spoiled Identity.*” Englewood Cliffs: Prentice-Hall, Inc., p. 18.

⁹⁴Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., Scott, R. (1984). “*Social Stigma: The Psychology of Marked Relationships.*” New York: Freeman; 1st Edition, p. 50.

⁹⁵Lloyd, C. (2010). “Sinning and Sinned Against: The Stigmatization of Problem Drug Users.” Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed: 14.08.2013.

⁹⁶Kelly, J.F. and Westerhoff, C.M. (2010). “Does It Matter How We Refer to Individuals with Substance-Related Conditions?” A randomized study of two commonly used terms, *International Journal of Drug Policy*, 21 (3), pp. 202-7.

⁹⁷Melanie, C., Scott, P., Otto, F.W. (2011). “Substance Abuse Stigma and Discrimination among African American Male Substance Users,” *Stigma Research and Action*, 1(1), pp. 60-66.

withdrawal coping strategies are aimed at isolating these individuals from family members, friends, employers, and co-workers, so that they can avoid the stigma associated with drug use.⁹⁸

Yet another coping strategy is the guidance and counseling strategy. Most individuals with drug use problems approach psychotherapists in order to be guided on how they can cope with the substance use stigma effectively. A psychotherapist formulates a short-term and a long-term addiction recovery plan to help them overcome the substance use stigma.⁹⁹

According to Gourlay et al. (2005), other stigma-coping strategies that are employed by individuals with drug use problems include, but are not limited to, the following: preventive disclosure, compensation, strategic interpretation, and political activism.¹⁰⁰ The preventive disclosure strategy is aimed at selective disclosure of the status of 'drug user' to selected individuals in order to test acceptability. The compensation strategy aims at using an individual's strength in other areas in order to counter the drug stigma imposed on the individual. Gourlay et al. (2005) continue to postulate that individuals with drug use problems will engage in some sporting activities as a means of counteracting the imposed stigma. On the other hand, the strategic interpretation strategy is aimed at comparing oneself with other members of the stigmatized group as opposed to the comparison with people outside the stigmatized group. At the same time, as noted by Herman (1993), some individuals with drug use problems resort to political activism as a way of coping with the imposed drug stigma.¹⁰¹ Such individuals get involved in various political activism campaigns, as well as in campaigns that are geared towards sensitizing the general public about drug use and addiction. The involvement of such individuals in political activism is normally aimed at framing the public image about the drug user as a normal individual who can participate in various goodwill public initiatives.

In their study entitled *Social Setting, Stigma Management, and Recovering Drug Addicts*, Anderson and Ripullo (1996) discuss various stigma-coping strategies that are employed by individuals with drug dependence.¹⁰² These strategies include the following: the concealment strategy, the spoiling identities and education strategy, the normalization strategy, and the passing judgment strategy. The spoiling

⁹⁸Link, B. G., Struening, E.L., Rahav, M., Phelan, J.C., Nuttbrock.L. (1997). "On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with a Dual Diagnosis of Mental Illness and Substance Abuse," *Journal of Health and Social Behavior*, 38 (1), pp. 177-190.

⁹⁹Kersey-Matusiak, G. (2013). "*Delivering Culturally Competent Nursing Care*." New York, NY: Springer Pub. Co.

¹⁰⁰Gourlay, J., Ricciardelli, L., Ridge, D. (2005). "Users' Experiences of Heroin and Methadone Treatment," *Substance Use and Misuse*, 40(12), pp. 1875-1882.

¹⁰¹Herman, N. (1993). "Return to Sender: Reintegrative Stigma-Management Strategies for Ex-Psychiatric Patients," *Journal of Contemporary Ethnography*, 22(3), pp. 302-321.

¹⁰²Anderson, T.L. and Ripullo, F. (1996). "Social Setting, Stigma Management, and Recovering Drug Addicts," *Humanity & Society*, 20(3), pp. 26-43.

identities and education strategy involves approaches where individuals with drug dependence risk spoiling their identities in order to reveal discrediting information to other members of society, if they believe that the information is going to prevent other individuals from becoming members of their group. As noted by Herman (1993), this strategy is aimed at educating, and at establishing shared identities among, individuals with drug use problems.¹⁰³ According to Katovich and Couch (1992), the strategy also aims at creating interaction between individuals with drug problems and forming a framework for sharing experiences.¹⁰⁴

Another drug stigma-coping strategy discussed by Anderson and Ripullo (1996) is the normalization of stigma in family interactions. Anderson and Ripullo (1996) state that various individuals with drug dependence become engaged in normalized activities in order to effectively cope with stigma from family members. The same sentiments were also echoed by Anspach (1979). According to Anspach (1979), by normalizing their deviance, the individuals with drug dependence managed to recover their 'addict identities' in such a way as to foster a more positive interaction and identification with them.¹⁰⁵ The normalization strategy is aimed at fostering the acceptance of individuals with drug use problems into the family as their conventional world. The coping technique is directed at re-uniting individuals with drug use problems with their family members, as well as at developing the best strategies that can help them normalize their lives. Yet another stigma-coping strategy described by Anderson and Ripullo (1996) is the passing judgment approach. As noted by these scholars, this approach is 'a management strategy that serves a defensive or preventive function for our respondents against re-identification as an addict. Respondents reported passing judgment on others to reconcile the potential discomfort emanating between those who remained abstinent and those who resumed alcohol or drug use.'¹⁰⁶

Despite the fact that there are various coping strategies and that individuals with drug use problems use them to decrease the negative influence of stigma- with some of them even struggling to normalize their lives-, stigma still remains severe and continues to have a negative impact on the treatment and recovery of individuals with drug dependence.

¹⁰³Herman, N. (1993). "Return to Sender: Reintegrative Stigma-Management Strategies for Ex-Psychiatric Patients," *Journal of Contemporary Ethnography*, 22(3), pp. 302-321.

¹⁰⁴Katovich, M. and Couch, C. (1992). "The Nature of Social Pasts and Their Use as Foundations for Situated Action," *Symbolic Interaction*, 15(1), pp. 25-48.

¹⁰⁵ Anspach, R. (1979). "From Stigma to Identity Politics: Political Activism among the Physically Disabled and Former Mental Patients," *Social Science and Medicine*, 13(A), pp. 350-363.

¹⁰⁶Anderson, T.L. and Ripullo, F. (1996). "Social Setting, Stigma Management, and Recovering Drug Addicts," *Humanity & Society*, 20(3), p. 36.

Negative effects of stigma on treatment and recovery of individuals with drug use problems

Stigmatization is considered a major barrier to the effective treatment and recovery of individuals with drug use problems. As noted by Walters and Rotgers (2012), some individuals with drug dependence avoid enrolling in and adhering to treatment and recovery options because they fear ridicule and objection from family members and friends.¹⁰⁷ For instance, ‘A pervasive myth is the notion that individuals who are taking a medication for their opioid or alcohol addiction (and, to a lesser extent, a medication for a psychiatric condition) are not in recovery, and that they are replacing one drug for another.’¹⁰⁸ Research demonstrates that there is a stigma towards individuals who are enrolled in drug treatment in order to try to stop using drugs. The stigma turns out to be especially strong towards methadone users.¹⁰⁹

Three qualitative studies conducted in the 1980s by Murphy and Irwin (1992), which are described in the paper *The Stigma of Substance Use: A Review of the Literature*,¹¹⁰ showed that the methadone patients surveyed in the studies were perceived as having a ‘marginal identity.’ The methadone patients viewed themselves and were viewed by society as deviant, despite their efforts to end their addiction.¹¹¹ These studies emphasize that, instead of normalizing their lives, individuals entering methadone treatment attain a deviant status and are stigmatized by society as former heroin users.¹¹² According to Murphy and Irwin (1992), people in methadone therapy need to struggle to ‘conceal’ their marginal status and to apply various coping strategies, though the authors reported that the coping strategies used by patients were mostly perceived negatively by people in their social networks who did not know that

¹⁰⁷Walters, S. T. and Rotgers, F. (2012). “*Treating Substance Abuse: Theory and Technique*.” New York: Guilford Press.

¹⁰⁸ McIntosh, L. “Addiction Messenger.” Available at: <http://atforum.com/addiction-resources/documents/MATPart2.pdf> Accessed: 5.12.2013.

¹⁰⁹ White, W.L. (2009). “Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia” (with particular reference to medication-assisted treatment/recovery), Philadelphia Department of Behavioral Health and Mental Retardation Services. Available at:

<http://www.facesandvoicesofrecovery.org/pdf/White/StigmaMedicationTreatment.pdf>, Accessed: 6.08.2013.

¹¹⁰Center for Addiction and Mental Health (1999). “The Stigma of Substance Use: A Review of the Literature.” Available at:

http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_sub_abuse_litreview99.pdf, Accessed: 8.08.2013.

¹¹¹Murphy, S. and Irwin, J. (1992). “Living with the Dirty Secret: Problems of Disclosure for Methadone Maintenance Clients,” *Journal of Psychoactive Drugs*, 24(3), p. 258.

¹¹²Center for Addiction and Mental Health (1999). “The Stigma of Substance Use: A Review of the Literature.” Available at:

http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_sub_abuse_litreview99.pdf Accessed: 8.08.2013.

the patients were in methadone treatment.¹¹³ It is obvious that the fear of being stigmatized leads to secrecy about methadone treatment. The question we face is why methadone treatment results in such stigma. In his paper, White (2009) offers a discussion about stigma towards methadone patients, referring to Vigilant's (2001) explanation that the severe stigma towards methadone treatment and its patients could be attributed to the imperfect medicalization of chronic opioid addiction and its treatment.¹¹⁴ Vigilant (2001) stresses two important factors when discussing imperfect medicalization. Firstly, he notes that methadone clinics have not achieved the social status of a medical clinic because they are not allowed to operate like a medical clinic, and, in addition, he explains that methadone patients have yet to achieve the full status of 'patients' because they have not been treated as such.¹¹⁵

This stigmatization ideology has led some individuals with drug use problems to avoid treatment and recovery options due to fear of ridicule and rejection. The same sentiments are expressed by Johnson (2011) who states that a person who is under a recovery program or uses drugs may avoid treatment due to the stigma and fear of rejection.¹¹⁶ Johnson (2011) argues that the effect of self stigma may prevent recovery by reducing the motivation of individuals with substance dependence problems and by creating negative beliefs about their capacity to recover, resulting in relapse.¹¹⁷

Stigma towards individuals with drug use problems affects the treatment and recovery of these individuals very negatively in the sense that they are denied basic treatment and recovery services by various healthcare facilities due to discrimination. For instance, 'Insurance coverage for treatment is often denied or restricted, and employers turn away recovering individuals that report their drug histories 75% of the time.'¹¹⁸ In addition, 'Individuals report several concerns related to accessing treatment, such as the possible negative effects on their job (13.3 percent), concern that neighbors and the community will have a negative opinion of them (11.0 percent), and lack of healthcare coverage

¹¹³Murphy, S. and Irwin, J. (1992). "Living with the Dirty Secret: Problems of Disclosure for Methadone Maintenance Clients," *Journal of Psychoactive Drugs*, 24(3), p. 262.

¹¹⁴Vigilant, L. G. (2001). "Liquid Handcuffs: The Phenomenology of Recovering on Methadone Maintenance," *Boston College Dissertations and Theses*. Vigilant, L. G. (2008). "I Am Still Suffering: The Dilemma of Multiple Recoveries in the Lives of Methadone Patients," *Sociological Spectrum*, 28, pp. 278-298. Vigilant, L. G. (2005). "I Don't Have Another Run Left with It: Ontological Security in Illness Narratives of Recovery on Methadone Maintenance," *Deviant Behavior*, 26(5), pp. 399-416.

¹¹⁵Vigilant, L. G. (2001). "Liquid Handcuffs: The Phenomenology of Recovering on Methadone Maintenance," *Boston College Dissertations and Theses*.

¹¹⁶Johnson, B. A. (2011). "Addiction Medicine: Science and Practice." New York: Springer.

¹¹⁷ Ibid.

¹¹⁸"Briefing on Substance Use Treatment and Recovery in the United States" (Executive Summary). Available at: http://partnersforrecovery.samhsa.gov/docs/Briefing_Substance_Use_Treatment.pdf, Accessed: 5.12.2013.

(36.3 percent).¹¹⁹ Research demonstrates that the provision of a wider range of interventions is often associated with better treatment outcomes for individuals with drug dependence,¹²⁰ and, therefore, these individuals' access to employment, education, training, accommodation, and psychiatric services seems to be very important to their rehabilitation. Stigma also turns out to be a significant barrier preventing employers from hiring people who either have or have had drug dependence problems. For example, Klee et al. (2002) found that 'Stereotypes of individuals with drug use problems in society are a major barrier to them returning to working life. In general, they are seen as deviant, dishonest, unreliable, manipulative individuals prone to poor health and self-neglect'.¹²¹

The afore-mentioned sentiments indicate the negative impacts of stigma on treatment and recovery options for individuals with drug use problems. It is evident that stigma plays a major role as one of the main barriers to effective administration of treatment and recovery options for such individuals. For instance, individuals with addiction problems may avoid treatment options due to the fear of rejection and condemnation from family members, as well as from the general public. At the same time, stigma has escalated discrimination against these individuals on the part of healthcare professionals and healthcare institutions. Trying to cope with and struggle against stigma is a very long-lasting and complex process. As Ben-Yehuda (1990) notes: 'The only way to neutralize the deviant stigma is to create a counter-movement that would attempt to use, or generate, power and to redefine morality and create a new symbolic-moral universe. Thus, the collective search for identity is not monopolized by deviant-producing groups. It also involves deviants who may try to organize themselves and successfully generate enough power and public support for their version of morality and for their collective attempts to de-stigmatize themselves. Since deviantization processes have a moral-political base (although often obscure), the only means of reversal is a change in, or challenge to, that moral-political base.'¹²²

¹¹⁹Ibid.

¹²⁰McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., Durell, J. (1998). "Supplemental Social Services Improve Outcomes in Public Addiction Treatment," *Addiction*, 93 (10), pp. 1489–99.

¹²¹Klee, H., McLean, I., Yavorsky, C. (2002). "Employing Drug Users – Individual and Systematic Barriers to Rehabilitation," p. 4. Available at: <http://www.jrf.org.uk/sites/files/jrf/1842630830.pdf>, Accessed: 5.12.2013.

¹²²Ben-Yehuda, N. (1990). *The Politics and Morality of Deviance: Moral Panics, Drug Abuse and Reversed Stigmatization*. Albany: State University of New York Press, pp. 66-67.

Focusing on women with drug use problems and its implications from the gender perspective

The literature demonstrates that females and males with drug use problems differ in many ways, including the patterns of drug use, psycho-social characteristics, physiological consequences of drug use, and treatment needs.¹²³ There are many studies which suggest that men and women start to experiment with drugs for different reasons, give priority to different substances, develop the syndrome of drug dependence in different ways, and encounter different difficulties and problems due to their dependence on drugs.¹²⁴ Various studies have been undertaken in the recent past in order to investigate the characteristics of women with drug use problems as well as their stigmatization.

Kauffman et al., (1997) states that women with substance abuse problems are viewed in a more negative manner from society and that the social stigma towards women with drug use problems may act as a deterrent for them.¹²⁵ According to Nelson-Zlupko et al (1995), women with drug use problems, in most cases, are more likely to come from families where one or several members of the family are associated with drug use. Nelson-Zlupko et al.(1995) go on to state that drug use amongst women is attributed to environmental stress, genetic predisposition and family history.¹²⁶ However, research makes it obvious that the most significant problem regarding female drug use, which makes it peculiar and different from the male experience, is related to particular life experiences among which violence and women's victimization play a significant role.

Overall research demonstrates that women tend to be victims of physical and sexual abuse more often than men do and most often the perpetrators of the violence tend to be spouses and sexual partners. A study conducted on women in Georgia – *National Research on Domestic Violence against Women in Georgia* (2010) – makes it clear that one of every 11 women in a marriage or serious relationship has been a victim of physical or sexual violence.¹²⁷ A national survey conducted in Canada also

¹²³Nelson-Zlupko, L., Kauffman, E., Dore, M. M. (1995). "Gender difference in drug addiction and treatment: Implications for social work intervention with substance-abusing women," *Social Work*, 40(1), pp. 45-54.

¹²⁴ Anderson, T. L. (2001). "Drug Use and Gender." *Encyclopedia of Criminology and Deviant Behavior*, Vol. IV: Self-Destructive Behavior and Devalued Identity, pp. 286-289.

¹²⁵Kauffman, S.E & Silver, P & Poulin, J. (1997). "Gender differences in attitudes toward alcohol, tobacco, and other drugs," *Social Work*, 42(3), pp. 231-241.

¹²⁶Nelson-Zlupko, L., Kauffman, E., Dore, M. M. (1995). "Gender difference in drug addiction and treatment: Implications for social work intervention with substance-abusing women," *Social Work*, 40(1), pp. 45-54.

¹²⁷Chitashvili, M., Javakhishvili, N., Arutiunov, L., Tsuladze, L., Chachanidze, S. (2010). "National Research on Domestic Violence against Women in Georgia." Available at: <http://www.genderbasedviolence.ge/conimages/annual-eng.pdf>, Accessed: 5.07.2013.

demonstrates that approximately 1 in 3 women have experienced violence at some point in their adult lives and that 1 in 10 women are presently experiencing violence.¹²⁸

Feminist literature about violence and abuse provides insight into male power and domination.¹²⁹ Within a patriarchal social order men maintain a privileged position through their domination of women and their monopoly of social institutions. Feminists look to the historical roots of these inequities to explain the deeply gendered division of power in contemporary society.¹³⁰

As an example Rosemary Radford Ruether (1989) concludes that domestic violence against women is historically 'rooted in and is the logical conclusion of basic patriarchal assumptions about women's subordinate status.'¹³¹ Moreover, research shows that batterers often blame the woman they have victimized for the violence, either implicitly or explicitly, and other people, including police, judges, and juries, often accept this argument.¹³² Male abusers often justify their aggression and violence towards their wives, arguing that wives were responsible for the abuse because they were not submissive and/or they did not fulfill their marital obligations.¹³³ Moreover, being battered by one's own husband was and in some societies is still considered a family matter and not on a par with other assaults.¹³⁴ According to Dobash and Dobash (1979) this situation began to change when a coalition of New York lawyers in 1976 instituted a class action suit against the New York City Police Department on behalf of twelve women who suffered from domestic violence.¹³⁵ The suit alleged that the police department had denied them legal protection by discriminating against wives by treating the wives of abusive husbands differently from victims of assault by strangers.¹³⁶ The plaintiffs won, and the New

¹²⁸ Canadian Women's Foundation (2011) "Report on Violence Against Women, Mental Health and Substance Use." Available at: http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resources%20-%20BCSTH%20CWF%20Report_Final_2011_%20Mental%20Health_Substance%20Use.pdf, Accessed: 18.09.10

¹²⁹ Johnson, H. (1996). *"Dangerous Domains: Violence Against Women in Canada."* Toronto: Nelson Canada.

¹³⁰ Yllö, K.A. (1993). *"Through a feminist lens: Gender, Power, and Violence."* In Gelles, R.J. and Loseke, D.R. (eds.), *"Current Controversies on Family Violence."* Newbury Park, CA: Sage Publications, pp. 47-62.

¹³¹ Ruether, R.R. (1989). *"The Western Religious Tradition and Violence against Women in the Home."* Christianity, Patriarchy, and Abuse. Ed. Joanne Carlson Brown and Carole R. Bohn; Cleveland, OH: Pilgrim, p. 31.

¹³² Dobash, R.E., Dobash, R. (1997). *"Violence against Wives."* New York: Free Press.

¹³³ Ptacek, J. (1988). *"Why do Men batter their Wives?"* In *Feminist Perspectives on Wife Abuse*, edited by Kersti Yllo, K. and Bogard., M. Newbury Park, CA: Sage.

¹³⁴ Pleck, E. (2004). *"Domestic Tyranny: The Making of American Social Policy Against Family Violence from Colonial Times to the Present."* Champaign, IL: University of Illinois Press.

¹³⁵ Dobash, R.E., Dobash, R. (1997). *"Violence against Wives."* New York: Free Press, p. 237.

¹³⁶ Ibid.

York Supreme Court acknowledged in its decision that for a long time such abuse has continued unpunished due to legal inequality.

The situation is similar in cases justifying rape and sexual violence against women. Women victims are frequently blamed to have provoked their rapists by the way they behaved or dressed.¹³⁷ Brownmiller (1975) in her classic feminist work on rape states that early on in human history, ‘rape became man’s basic weapon of force against woman’ and became the ultimate ‘triumph of manhood...’ Rape has played a critical function. It is nothing more or less than a conscious process by which all men keep all women in a state of fear.’¹³⁸

It appears that male domination and societal norms are those factors which directly and/or indirectly excuse violence against women¹³⁹ and this problem is much more visible when it concerns female mental health and drug use.¹⁴⁰ As stipulated by Najavitis (2002), most females with drug use problems attribute their drug use to physical or sexual abuse, or traumatic experience.¹⁴¹ The same sentiments are postulated by the US department of Health and Human Services (2002). According to the US dept of Health and Human services (2002), most women with a substance abuse problem tend to attribute their substance abuse to physical, sexual or traumatic experience. Also, Bloom and Covington (1998) state that 70 percent of women in substance abuse treatment have histories of physical or sexual abuse.¹⁴²

For example, a Norwegian study has shown that women with hard drug use problems who were admitted to treatment had experienced more childhood emotional and sexual abuse and neglect than males.¹⁴³ It is obvious that very often drugs are used as a coping mechanism to deal with the distress associated with being a victim of violence.^{144/145} As postulated by Najivitis (2002), women who have

¹³⁷Common myths about rape. Available at: <http://www.rapecrisis.org.uk/commonmyths2.php>, Accessed: 25.09.13.

¹³⁸Brownmiller, S. (1975). “*Against Our Will.*” New York: Simon and Schuster, p. 5.

¹³⁹Bennett, L.W. (1995). “Substance Abuse and the Domestic Assault of Women,” *Social Work*, 40(6), pp. 760–772.

¹⁴⁰Humphreys, C., Thiara, R.K., Regan, L. (2005). “Domestic violence and substance use: overlapping issues in separate services?” Summary Report. London Domestic Violence Project: London. Available at: http://www2.warwick.ac.uk/fac/soc/shss/swell/research/final_report.pdf, Accessed 25.09.13.

¹⁴¹Najavits, L. M. (2002). “Seeking safety: therapy for trauma and substance abuse,” *Corrections Today*, 64(6), pp. 136-139.

¹⁴²Bloom, B., Covington, S. (1998). “Gender-Specific Programming for Female Offenders: What is It and Why is It Important?” Paper presented at the 50th annual meeting of the American Society of Criminology. Available at: <http://www.stephaniecovington.com/pdfs/13.pdf>, Accessed: 27. 04. 2012.

¹⁴³Ravndal, E.(2003). “Childhood Maltreatment among Norwegian Drug Abusers in Treatment,” *International Journal of Social Welfare*, 10, pp. 142-147.

¹⁴⁴Moran, PP., Vuchinich, S., Hall, N. (2004). “Associations between Types of Maltreatment and Substance Use During Adolescence,” *Child Abuse and Neglect*, 28, pp. 565-574.

repressed memories of a particular traumatic experience normally show a significant increase in the use of drugs or alcohol when such experiences re-emerge.¹⁴⁶ Brown (2000) also provides same statements and explains that women with severe post-traumatic stress disorders (PTSD) are more likely to relapse than those with less acute symptoms. A study involving a sample of women reporting three re-experiencing symptoms (i.e., flashbacks, memories of trauma, and nightmares) at intake were four times more likely to relapse within six months of concluding treatment for co-occurring substance use/PTSD than women reporting only one re-experiencing symptom.¹⁴⁷

The Report by the Canadian Women's Foundation presents a comprehensive review of studies demonstrating a strong correlation between violence and substance use.¹⁴⁸ For example, the report acknowledges the importance of a study conducted in Vancouver which demonstrates that from 248 women who responded to women's addiction treatment 63 percent had experienced physical and 41 percent sexual violence as adults.¹⁴⁹ Furthermore, 48 percent and 46 percent of the women had been exposed to physical and sexual violence as children, respectively. Fifty-two percent of the women were also given antidepressants at the time of treatment and 33 percent reported symptoms of eating disorders.¹⁵⁰

Research also shows that victimized women with drug use problems are not only blamed for being responsible for the abuse, but violence against them is most often justified as well. Overall, studies demonstrate that victims who are under alcohol or drug influence are more likely to be blamed than sober victims, and aggression towards an inebriated victim is considered more acceptable than aggression towards a sober one.¹⁵¹ For example, in a survey across seven regions of Russia, 21 of respondents said that a wife's drug or alcohol addiction was a valid reason for her husband to beat

¹⁴⁵Clark, W. (2001). "Violent Traumatic Events and Drug Abuse Severity," *Journal of Substance Abuse Treatment*, 20, pp. 121-127.

¹⁴⁶Najavits, L. M. (2002). "Seeking safety: therapy for trauma and substance abuse," *Corrections Today*, 64(6), pp. 136-139.

¹⁴⁷Brown, P. J. (2000). "Outcome in female patients with both substance use and post-traumatic stress disorders," *Alcohol Treatment Quarterly*, 18(3), pp. 127-135.

¹⁴⁸Canadian Women's Foundation (2011). "Report on Violence Against Women, Mental Health and Substance Use". Available at: http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resources%20-%20BCSTH%20CWF%20Report_Final_2011_%20Mental%20Health_Substance%20use.pdf Accessed: 18.09.10

¹⁴⁹Ibid.

¹⁵⁰Ibid.

¹⁵¹Aramburu, B., Leigh, B. (1991). "For better or worse: Attributions about Drunken Aggression toward Male and Female Victims," *Violence and Victims*, 6(1), pp. 31-42.

her.¹⁵² However, it is also evident that very often women use substances in order to cope with traumatic experience and violence. For example the Canadian Women's Foundation makes it clear that many women who use legal or illegal substances and who access anti-violence services report using substances to cope with the violence, the result then effecting their physical and mental health and/or other stress factors in their lives (poverty, lack of safe and affordable housing, etc.).¹⁵³

Another no less important factor distinguishing women's drug use experiences from those of men are the reasons for drug use. Scholars like Pelissier and Jones (2005) provide a wonderful 'Review of Gender Differences among Substance Abusers' and describe *gender differences* among individuals with substance use problems.¹⁵⁴ When reviewing the age of first drug use, Pelissier and Jones (2005) report that men begin using illicit substances at an earlier age than women do.¹⁵⁵ With regard to the reasons for drug use, Pelissier and Jones (2005) refer to those studies which demonstrate that men cite hedonistic motivations or pleasure-seeking and peer-pressure among the reasons for using drugs for the first time, while reasons provided by women include alleviation of physical or emotional pain, social reasons, or having a spouse who uses drugs.¹⁵⁶ The same arguments are presented by Powis (1996), who found that women who injected heroin were significantly more likely than men to have a sexual partner who also injected heroin (96 percent vs 82 percent).¹⁵⁷ In addition, according to Powis (1996) women were also more likely than men to be introduced to injection by their sexual partners.¹⁵⁸ Powis (1996) reported that 51 percent of the female heroin users were first injected by their male sexual partner, whereas 90 percent of men were injected the first time by a friend.

Findings presented in the report of the Canadian Women's Foundation also show that abusive partners play a significant role in women's substance use.¹⁵⁹ Many women reported that their partners made

¹⁵²Pinkham S, Malinowska-Sempruch, K. (2007). *Women, Harm Reduction and HIV*, New York: International Harm Reduction Development Program of the Open Society Institute. Available at: <http://www.hivpolicy.org/Library/HPP001574.pdf>, Accessed: 26.09.13.

¹⁵³Canadian Women's Foundation (2011). "Report on Violence Against Women, Mental Health and Substance Use." Available at: http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resources%20-%20BCSTH%20CWF%20Report_Final_2011_%20Mental%20Health_Substance%20use.pdf, Accessed: 18.09.10

¹⁵⁴Bernadette Pelissier and Nicole Jones (2005). "A Review of Gender Differences among Substance Abusers." Available at: http://www.bop.gov/news/research_projects/published_reports/drug_treat/oregender_differences.pdf, Accessed: 2.03.13.

¹⁵⁵Ibid.

¹⁵⁶Ibid. Accessed: 2.03.13.

¹⁵⁷Powis, B. (1996). "The Differences between Male and Female Drug Users: Community Samples of Heroin and Cocaine Users Compared," *Substance Use and Misuse*, 31(5), pp.529-543.

¹⁵⁸ Ibid.

¹⁵⁹Canadian Women's Foundation (2011). "Report on Violence Against Women, Mental Health and Substance Use." Available at: http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resources%20-%20BCSTH%20CWF%20Report_Final_2011_%20Mental%20Health_Substance%20use.pdf, Accessed: 18.09.10

them use substances in order to gain control over them.¹⁶⁰ Research demonstrates that men who abuse substances often introduce women to alcohol or drugs, thereby increasing her dependence and his control.¹⁶¹ Many women describe how they began using substances or increased the frequency of substance intake as a response to abuse; how they felt temporarily safe after substance use, because it appeased their partners; and that efforts to stop using substances resulted in increased violence or control tactics from the abuser.¹⁶² Research shows that men who abuse substances exert considerable influence over women's addictive behavior, and that appears to be one of the most serious obstacles for women's treatment.¹⁶³ The result of being in an unhealthy relationship is that substance-using women face problems in seeking and completing treatment and remaining abstinent.¹⁶⁴

Regarding the treatment needs, much of the literature states that women with substance use problems require specialized, gender-specific services and that there are various barriers that have been identified as forming an obstacle towards effective treatment and recovery among women with drug use problems. According to Bride (2001), women have in the recent past shown a dismal performance with regards to substance abuse treatment options compared to their male counterparts. This is attributed to the fact that the rates of enrolment into treatment programs, the retention rates, and the completion of treatment rates are quite low in women as opposed to men. The various barriers to treatment that women face include, but are not limited to, the following: physiological complications, financial hardship and social isolation. The above factors play a significant role as barriers towards effective administration of treatment and recovery strategies among women with substance abuse problems.

One explanation of women's failure rates in treatment programs may be related to the fact that mostly traditional treatment programs are designed for males and no gender related concepts are taken into consideration.¹⁶⁵ In order to meet relapse criteria, punitive and vindictory activities are often used.¹⁶⁶ In contrast to males, females are more likely to experience higher levels of guilt and shame in

¹⁶⁰Ibid.

¹⁶¹Martin, S., Kilgallen, B., Dee, D., Dawson, S., & Campbell, J. (1998). "Women in a Prenatal Care/Substance Abuse Treatment Program: Links between Domestic Violence and Mental Health," *Maternal and Child Health Journal*, 2(2), 85-94

¹⁶²Ibid.

¹⁶³Bride, B.E. (2001). "Single-Gender Treatment of Substance Abuse: Effect on Treatment Retention and Completion," *Social Work Research*, 25(4), pp. 223-232.

¹⁶⁴Bloom, B., Covington, S. (1998). "Gender-Specific Programming for Female Offenders: What is It and Why is It Important?" Paper presented at the 50th annual meeting of the American Society of Criminology. Available at: <http://www.stephaniecovington.com/pdfs/13.pdf>, Accessed: 27. 04. 2012.

¹⁶⁵Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995). "Gender Difference in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women," *Social Work*, 40(1), pp. 45-54.

¹⁶⁶Ibid.

acknowledging their substance dependence problem.¹⁶⁷ Therefore, confrontational approaches which aim to increase guilt and shame are ineffective in the case of female patients.¹⁶⁸ As stipulated by Bloom and Covington (1998), the above traditional modalities also explain the low retention and treatment completion levels among women with substance use problems.

Another important barrier to be discussed regarding professional support among women is the lack of proper women's representation among healthcare professionals, administrators, and treatment staff. According to Nelson-Zlupko et al, (1995), female representation is particularly low in treatment staff (with more men working and counseling women and an environment which is not women-oriented and in which women have less opportunities to discuss their private problems and needs and have less support and understanding), and there typically appears to be a disproportionate number of male staff in positions of authority, leaving few female role models for the female clientele. This underpins the need for more female representatives in various healthcare institutions and facilities who will eventually act as role models to the female clientele and create a women-oriented environment. As noted by Pelissier and Jones (2005) women are seen as needing ancillary services that address a wide range of needs, like childcare and training in parenting, assistance with transportation, medical care, educational or vocational training, and assistance with housing.¹⁶⁹ However, the most important issue that should be addressed while delivering treatment services for substance-using women is the acknowledgement of the correlation between violence and substance use.

A lot of studies acknowledge the importance in considering the impact of domestic abuse on delivering treatment that is effective, accessible and meets the needs of women service users.¹⁷⁰ As the Canadian Women's Foundation demonstrates, approximately two-thirds of women accessing anti-violence services report that they began their problematic substance use following experiences of violence in their relationships.¹⁷¹ A study by Dutton et al. (2005) reviewed in the report by the Canadian Women's Foundation found that the risk of developing depression, post-traumatic stress disorder (PTSD),

¹⁶⁷ Hodgins, D.C., Ed-Guebaly, N., Addington, J. (1997). "Treatment of Substance Abusers: Single or Mixed Gender Programs?" *Addiction*, 92(7), pp. 805-812.

¹⁶⁸ Ibid.

¹⁶⁹ Bernadette Pelissier and Nicole Jones (2005). "A Review of Gender Differences among Substance Abusers." Available at: http://www.bop.gov/news/research_projects/published_reports/drug_treat/oregender_differences.pdf, Accessed: 2.03.13.

¹⁷⁰ Galvani, S., Humphreys C.(2007). "The Impact of Violence and Abuse on Engagement and Retention Rates for Women in Substance use Treatment." Available at:

http://www.nta.nhs.uk/uploads/nta_the_impact_of_violence_and_abuse_women.pdf, Accessed: 17.09.13.

¹⁷¹ Canadian Women's Foundation (2011). "Report on Violence Against Women, Mental Health and Substance Use." Available at: http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resources%20-%20BCSTH%20CWF%20Report_Final_2011_%20Mental%20Health_Substance%20use.pdf, Accessed: 18.09.10.

substance use issues or becoming suicidal was three to five times higher for women who had experienced violence in their relationships compared to women who have not.¹⁷² Therefore, it is of crucial importance to acknowledge the problems and background that females with drug use problems have. Some scholars like Irwin and Stoner (1991) have even assumed that the traditional treatment programs may even be contributing to women 'entering a revolving door of poor treatment.'¹⁷³

As Gignac (1999) writes: 'Use of the traditional disease model, or the 12-Step philosophy, with the focus on the addiction itself while not addressing the coexisting problems of women may even be detrimental.'¹⁷⁴ It may be determined that because of the traditional treatment ideology regarding mental health, women's substance use may be influenced by the dominant patriarchal ideology, which ignores women's agency, social problems and those environmental stressors which influence women's mental health conditions- and concentrates only on the psychological deviations of individuals. The problems of the traditional treatment approach in the case of female mental health are well demonstrated in the book by Phyllis Chesler (2005).¹⁷⁵ Chesler (2005) asserted that the mental health system is vastly male-dominated and sexist, discriminating and violating women's rights. She argued that because some women rejected the stereotypical and socially accepted female role, these women were diagnosed as being mad and having illnesses that reflect the acting out of the socially devalued female role (e.g., depression, sexual dysfunction).¹⁷⁶

All the above-mentioned arguments outline the importance of recognizing the comprehensive range of women's problems while working in the mental health and drug treatment sphere and providing female-oriented services.

Most of the social science literature which deals with this issue emphasizes that stigma due to drug use experiences by women is much more severe than it is among the majority of men. Studies make it obvious that women who use substances are looked at as failing as partners, mothers or sisters and are perceived as deviants who are breaking the socially and morally accepted standards. These kinds of

¹⁷²Ibid.

¹⁷³Irwin, P.P. and Stoner, S.B. (1991). "Women's chemical dependency treatment program: A pilot study," *Alcoholism Treatment Quarterly*, 8, 123-130.

¹⁷⁴Gignac, S. (1999). "Substance Abuse and Women: a Comprehensive Qualitative Analysis of the Literature." Available at: https://www.google.ge/webhp?source=search_app&gws_rd=cr&ei=dgSPUpOOGcaY4gSTjIHABA#q=women+drug+users+reportedly+experience+sexual+harassment+from+counselors%2C+other+program+staff%2C+or+male+clients, Accessed: 22.11.13.

¹⁷⁵Chesler, P.(2005). "Women and Madness." Palgrave Macmillan.

¹⁷⁶Ibid.

women most often experience 'double deviance'- the extremely negative stereotype that women who use substances are, in addition to being addicted, sexually promiscuous because of their drug or alcohol use.¹⁷⁷ This 'double deviance' relates to notions of the traditional 'place' which women have occupied in society. According to Schur (1983) '...women's behavior is subject to considerable normative regulation',¹⁷⁸ that is well demonstrated in the social response to women who use illicit substances.¹⁷⁹

Traditionally, women hold relatively disadvantaged positions in the social system that guarantees their subordination by men. The social norms confine women to households and define their roles as being biased towards bringing up and taking care of the family. Women are supposed to be well-behaved and well-mannered and should be nurturers and role models in society. The societal framing of women has largely escalated the stigma towards women with drug addiction. A woman who defies such roles and responsibilities is considered an outcast in society, a bad person, a deviant, and someone who has 'transgressed against the social norms of being a good woman'¹⁸⁰. This stereotypic societal inclination has escalated and intensified the stigma towards women with drug use problems. The consequences are that women place these stereotypes and social norms upon themselves and are ashamed and feel guilty about their problem of abuse.¹⁸¹ The shame and guilt could be escalated by stigma, which can also be expressed in terms of self-stigma. Self-stigma can be generally defined as the manner in which the individual views oneself- a concept of self-perception. Women with substance use problems tend to have higher and more severe expressions of self-stigma. Research demonstrates that women with drug use problems mostly characterize themselves as having limited social networks and friends in general¹⁸² and lack various social opportunities. They prefer to stay invisible and hide their addiction problems from society.¹⁸³ Women are considered to be more likely to abuse drugs and alcohol in

¹⁷⁷ Copeland, J. (1997). "Barriers to Formal Treatment Among Women who Self managed Change in Addictive Behaviors," *Journal of Substance Abuse Treatment*, 14(2), p.186.

¹⁷⁸ Schur, E. M. (1983). *Labeling Women Deviant: Gender, Stigma, and Social Control.* Philadelphia: Temple University Press. pp.81.

¹⁷⁹ Center for Addiction and Mental Health (1999). "The Stigma of Substance Use: A Review of the Literature." Available at:

http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_sub_abuse_litreview99.pdf, Accessed: 8.08.13.

¹⁸⁰ Bloom, B., Covington, S. (1998). "Gender-Specific Programming for Female Offenders: What is It and Why is It Important?" Paper presented at the 50th annual meeting of the American Society of Criminology. Available at: <http://www.stephaniecovington.com/pdfs/13.pdf>, Accessed: 27 04. 2012.

¹⁸¹ Ibid.

¹⁸² Kauffman, S.E & Silver, P & Poulin, J. (1997). "Gender Differences in Attitudes Toward Alcohol, Tobacco, and other Drugs," *Social Work*, 42(3), pp. 231-241.

¹⁸³ Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995). "Gender Difference in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women," *Social Work*, 40(1), pp. 45-54.

private places, while men are deemed to be likely to abuse drugs in social set-ups such as bars, clubs or at parties. In their personal lives women are seen as lonely, unhappy, lacking self-confidence, or destructive. Their femininity is depicted as 'misplaced,' 'rejected,' or 'insufficient.'¹⁸⁴ This fact also underpins the social construction of stigma towards women with drug abuse problems compared to males.¹⁸⁵

Ridlon (1988) argues that according to widespread stereotype, alcohol use in women will result in a loosening of control over their sexual drives¹⁸⁶ and that's why "drunken women" are likely to be stigmatized as sexually indiscriminate and 'available.' Ridlon (1988) names this fact as 'double standards' and explains that there is no such stereotypical pairing of drinking alcohol with sexual promiscuity in the case of men. The existence of 'double standards' increases stigmatization for female alcoholics.¹⁸⁷ The same sentiments are expressed by Chesler (2005) who argued that due to 'double standards' in the case of women, women are often punitively labeled as a function of gender, race, class, or sexual preference.¹⁸⁸ Chesler (2005) argued that women compose a greater number of psychiatric patients in contrast to men. But this does not happen because women are notably more ill, but because women are socially marked as the 'weaker' sex -- not just physically, but mentally.¹⁸⁹ Women's subordinated social role has led to depression, and their lack of acceptable outlets has likewise led to long 'careers' as psychiatric patients. Chesler (2005) notes that female patients suffering from often-debilitating medical conditions like lupus and chronic fatigue syndrome are regularly treated as having 'just' a psychiatric illness; that psychiatric counseling for rape victims will always be used by the defense to portray the victim as either crazy or promiscuous at rape trials; and that class and race stereotypes (wealthy white women are bored, not depressed; women of color are 'stronger' than their less oppressed counterparts) are rife in psychiatric medicine.¹⁹⁰

As Ridlon (1988) identified, because of the double standards and severe stigmatization, women's problems with substance misuse may become actively 'hidden' from family and friends. This represents

¹⁸⁴Frišaufová M. (2012). "The Female Drug User as a 'Victim' or 'Villain' and the Implications for Social Work," *Social Work and Society*, 10(1). Available at: <http://www.socwork.net/sws/article/view/313/657>, Accessed: 11.09.13.

¹⁸⁵Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995). "Gender Difference in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women," *Social Work*, 40(1), pp. 45-54.

¹⁸⁶Ridlon, F. V. (1988). "*A Fallen Angel: The Status Insularity of the Female Alcoholic.*" Lewisberg: Bucknell University Press, p.25.

¹⁸⁷Ibid.

¹⁸⁸Chesler, P.(2005). "*Women and Madness.*" Palgrave Macmillan.

¹⁸⁹Ibid

¹⁹⁰Ibid.

an effort to avoid a stigmatizing label. The fear of being stigmatized also acts as a ‘barrier’ for women to get treatment for alcoholism or other drug use.¹⁹¹

Another dimension of stigma towards women who have problems with drug use is evident in the manner in which such women are treated by various healthcare professionals. Healthcare professionals and therapists normally treat women with some level of bias. The female clients are often described as non-compliant, difficult to handle, and unresponsive to treatment. As stipulated by Nelson-Zlupko et al (1997), these perceptions of professionals often become a self-fulfilling prediction, which leads to a dramatic decrease in women’s chances of succeeding in treatment and achieving abstinence.¹⁹² According to Hodgins et al (1997), many women reportedly experience sexual harassment from counselors, other program staff, or male clients.¹⁹³ Also Chesler (2005) demonstrated how often females with mental health problems were sexually abused and mistreated.¹⁹⁴ In her book *Women and Madness*, Chesler (2005) described the historical mistreatment of women in the service of ‘curing’ them. Analysis of the profiles of prominent 19th and 20th century clinicians, case histories of psychiatric patients, in-depth interviews, and analyses of treatment methods assert that female patients were systematically abused by doctors and institutions. Most often women were delivered into treatment by their family members not just because they were suffering from depression or nervousness but also because they were frigid, ‘unfeminine,’ victims of rape in childhood or just plain non-conformist. Women who were treated by male psychiatrists were humiliated, looked down upon, and often encouraged to have sex with their doctors as a ‘cure’ for their frigidity or daddy issues. In institutions, they were regularly subjected to deprivation and abuse by both staff and fellow inmates.¹⁹⁵

As an example, a study conducted by Boyd (1999) also demonstrates the cases of mistreatment and discrimination of female patients because of their drug use.¹⁹⁶ Boyd (1999) carried out in-depth interviews with pregnant women and mothers who were using prenatal and antenatal services. All of the women in her study had a history of illicit drug use and recounted severe stigma during their healthcare visits. While some women identified difficulty in accessing accurate information about the

¹⁹¹ Copeland, J. (1997). “Barriers to Formal Treatment among Women who Self Managed Change in Addictive Behaviors.” *Journal of Substance Abuse Treatment*, 14 (2), p.183.

¹⁹² Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995). “Gender Difference in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women,” *Social Work*, 40(1), pp. 45-54.

¹⁹³ Hodgins, D.C., Ed-Guebaly, N., Addington, J. (1997). “Treatment of Substance Abusers: Single or Mixed Gender Programs?” *Addiction*, 92(7), pp. 805-812.

¹⁹⁴ Chesler, P.(2005). “*Women and Madness*.” Palgrave Macmillan.

¹⁹⁵ Ibid.

¹⁹⁶ Boyd, S. C. (1999). “*Mothers and Illicit Drugs: Transcending the Myths*.” Toronto: University of Toronto Press.

risks associated with continuing use of specific drugs, including methadone, on the fetus, others reported to have been treated disrespectfully by physicians and other healthcare staff. Some of the women in Boyd's (1999) study felt that they were stigmatized by treatment staff as 'bad' women because of their drug use history and any history of prostitution. One woman even noted how she was continually ignored by doctors during her twenty years on methadone. Instead of speaking to her directly, the doctor always addressed her husband. A fear that their children would be apprehended by children's aid agencies was one of the greatest concerns of the women in Boyd's (1999) study.¹⁹⁷

As many women are the primary carers of dependent children, their problems with drug use and/or treatment retention are also influenced by their care responsibilities. The fear that their children could be taken away decreases the motivation and the desire of women to be involved in treatment and to stop using drugs. Studies show how many children have been taken away from drug using mothers and adopted out.¹⁹⁸ This means that women who had been using drugs and became drug-free will not be able to get their children back once those children have been adopted.

From the above analysis it is evident that women with drug use problems are faced with intense levels of stigma and violence compared to their male counterparts. This is attributed to social norms, beliefs, and culture that define the position of a woman in society. Also, feminism and masculine philosophy has largely contributed to increased stigmatization towards women with drug use problems. In a nutshell, the societal framing of the position of a woman in society and the position of a man in society can be considered as the major factor contributing to the increased level of stigmatization towards women with drug addiction.

Conclusion

The presented Chapter summarized some influential international studies and data regarding drug use and its implications. Based on the studies listed in the literature review we can outline important topics which should be mentioned and analyzed in the case of drug use and addiction. It is evident that the stigmatization process of people with drug use problems tends to take centre stage. Negative views are common throughout society, including among some professionals, and the severe stigma and

¹⁹⁷Ibid.

¹⁹⁸House of Representatives, Standing Committee on Family and Human Services (2007) "The Winnable War on Drugs: The Impact of Illicit Drug Use on Families." Available at: http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=fhs/illicitdrugs/report.htm, Accessed: 26.09.13.

discrimination of individuals with drug use problems has its impact on treatment and health consequences.

To be an individual with drug use problems means to have a status that greatly affects one's interactions with others - a status that frequently incites disgust, anger, judgment and censure in others. It is also evident that the stigmatizing attitudes of others have a profound impact on users' lives, leading to feelings of low self-worth and the avoidance of contact with non-users. Attending a drug treatment agency may also contribute to creating an 'addict' identity which can lead to further rejection from society and appears to be one of the serious reasons for delaying treatment.

Regarding the gender differences in drug use, literature demonstrates that women face much more severe problems because of using drugs than men do. Findings outline some very important topics which should be discussed and analyzed in the case of female drug use implications – patriarchy, male domination and societal norms - factors which are directly and/or indirectly connected with the sexual and physical abuse of women who might become dependent on illegal drugs due to these gender specific experiences. Simultaneously, the same discourses and societal norms suggest that those women who use drugs do not deserve respect and are seen as more deviant than their male counterparts. The greater stigma attached to women and the strong relationship between violence and female substance use seems to be very significant barriers for women in their daily life and recovery process.¹⁹⁹ Fear of social isolation, of losing love and support as well as their children causes women to delay asking for professional help.²⁰⁰ However, it is of crucial importance to acknowledge that the greatest difference in the case of male and female drug use lies not in their biological or psychological differences, nor in their particular treatment needs, but lies in the social context where male and female roles and obligations are differently defined and perceived.

¹⁹⁹ Copeland, J. (1997). "Barriers to Formal Treatment Among Women who Self Managed Change in Addictive Behaviors," *Journal of Substance Abuse Treatment*, 14(2), pp.183-190.

²⁰⁰ Finkelstein, N. (1994). "Treatment Issues for Alcohol and Drug-Dependent Pregnant and Parenting Women," *Health and Social Work*, 19(1), pp. 7-15.

Chapter 2

Research Methodology

Preparatory work and study techniques

The general aims of the dissertation are (i) to explore the gender differences in the case of Georgian men and women with substance use problems; (ii) to identify what kind of social and psychological problems and barriers Georgian men and women with substance use problems encounter in everyday life and during treatment; (iii) to demonstrate that society has more negative and stigmatized attitudes towards Georgian women with drug use problems than towards men; (iv) to demonstrate the link between violence and female substance use in Georgia and (v) to show the importance of analyzing drug use issues with the use of the gender perspective.

The original qualitative part of research aimed to gain an in-depth understanding of the characteristics of the situation, gain more knowledge about the gendered experiences and lifestyles of individuals with substance use problems, identify the reasons for their drug using and analyze the gendered barriers they face. For this reason the best applied research method appeared to be a qualitative one. I came to the decision that qualitative research was the exact tool that would help give me the possibility to gather data that describe drug use and associated behaviors from the perspectives of individuals with drug use problems. The qualitative research method was mostly applied in order to describe the social and physical settings in which drug use happens and the interaction of individual and social factors that influence drug-using behavior. Therefore, the choice to gather information for my research questions by applying qualitative methods appeared to be the first step forward after the literature review was completed.

Another important issue that needed to be addressed was identifying those individuals – research participants - who were expected to provide knowledge and information regarding the research questions I had addressed. It was obvious that I needed to sample individuals with drug use experience, however, while working on the literature review, the problem of limited and scarce studies in Georgia regarding drug use, drug policy, public attitudes towards individuals with drug use problems, drug treatment needs, etc. raised the necessity to gather more background information about the Georgian context and hence not rely purely on the western experience. In order to fulfill the above assignment I decided to obtain the necessary information about the Georgian context from individuals who are also very much familiar with drug use issues: the individuals working as drug rehabilitation professionals,

researchers studying drug treatment and prevention needs, and representatives of NGOs who are involved in harm reduction activities. For this reason, I decided to divide my research study participants into two groups – drug rehabilitation professionals (experts) and individuals with drug use problems– the so-called ‘experts with experience’ – in three cities of Georgia – Tbilisi (Population 1,171,200), Gori (Population 46,680), and Zugdidi (Population 69,600). These three cities were chosen for the following reasons: Tbilisi is the capital of Georgia and the two other cities (Gori and Zugdidi) were selected because of a relatively large number of women with drug use problems as compared to other cities in Georgia.



The next issue that had to be addressed was choosing the most comprehensive technique to gather data. As qualitative research method comprises various techniques, including in-depth interviews and focus group discussions to gather data, the next decision I had to make was to identify which one to use. In the beginning, while preparing for the fieldwork, I had a strong desire to conduct focus group discussions with experts as well as with individuals with drug use problems. The main difference between an in-depth interview and a focus group discussion lies in the interaction between group members. A focus group, which most often consists of four to eight participants, enables the researcher to explore and compare multiple opinions of different participants.²⁰¹ It also gives the possibility to collect diverse data in a relatively short time period. However, one major risk with FG discussions is that some individuals who are more active may dominate the discussion. Less active and expressive participants appear to be in a less privileged position, holding back from expressing their opinions,

²⁰¹ Mack, N., Woodsong, C., Maqueen, K.M., Guest, G., Namey, E. (2005). Qualitative Research Methods: A Data Collector's Field Guide. Available at: <http://www.fhi360.org/sites/default/files/media/documents/Qualitative%20Research%20Methods%20-%20A%20Data%20Collector's%20Field%20Guide.pdf>, Accessed: 28.09.13.

which may give a far from honest or real picture. Therefore, I understood that in the case of FG discussion with experts, some experts would be more active, more expressive and more influential because of their status and working experience and may affect others' ideas and opinions and change the whole picture. The situation appeared to be much more complex in the case of participants with drug use experience. Considering the sensitivity of my research topic, it is understood that individuals with drug use problems represent a so called hard to reach or 'hidden' population, a population for which there is no frame available for sampling purposes.

The *first* difficulty which would appear in the case of focus group discussion with participants with drug use experience would be the problem of anonymity. Those who use drugs may hide their drug problems and may be against exploring their drug experience in front of others, despite the fact that other participants may also share the same problems. The *second* problem which would hinder the success of a focus group discussion may be the discomfort the participants with drug use problems may experience in front of other group members while talking about their personal feelings, emotions, opinions and problems. With such a sensitive issue as drug use experience, its accompanying problems and barriers, I understood that it was crucial to ensure that the study participants express their views and attitudes in relation to the issues under study as frankly as possible. The probability of receiving a biased and incomplete picture made me change my mind about a focus group discussion and I decided to choose a more comprehensive and suitable technique, namely in-depth interviews which would contribute to my data collection.

The advantage of individual (or face-to-face) interviews in a study related to drug use problems is that face-to-face interviews offer a safer and more private environment which creates an atmosphere of trust, openness and confidentiality.²⁰² In individual interviews, it is much easier and safer to address the issues that are particularly sensitive, hidden and/or shameful and those that are considered a taboo. The choice of in-depth interview gave me more confidence and increased the probability of getting more honest and realistic answers from individuals with drug use problems as well as from drug rehabilitation experts. However, even individual interviews could not totally guarantee that I would obtain honest and detailed information from the study participants. Obviously, I was well aware of the difficulty I was facing in my effort to establish an open and confidential atmosphere between me and the study participants (especially in case of individuals with drug use problems).

²⁰²Ibid.

I thoroughly pre-planned each interview and in the course of a pilot interview (which I conducted with friends) I refined not only the interview guide, but also those professional methods that facilitated eliciting more sincerity and information from a respondent. These methods are known as ‘probing’ methods and are used by researchers/interviewers to nudge respondents to finish an idea which they have not fully explained, or to expand on a matter they may have touched on in passing. I think that probing was especially important during the interviews conducted with individuals who are dependent on drugs, because the topic of the study was a very complex, delicate and sensitive issue for them and at first most of them refrained from offering detailed and honest answers. Therefore, in the course of absolutely every interview, in different order and obviously in different cases, I had to use the following methods: ‘silent probe,’ ‘echo probe,’ and ‘statement probe.’²⁰³ It is worth noting that while using these methods I did not interfere in the conversation and did not influence respondents’ answers.

Often during the interviews (especially with individuals who had drug use problems), when I noticed that the respondent was trying to avoid talking about a specific issue, or his/her answers were very short and superficial, I resorted to a ‘silent probe’ method. The respondent expected me to ask another question during a pause in the interview, but I remained silent. In most cases this made the respondent ill at ease, so in order to remove the awkwardness from the situation he/she decided to fill the silence gap and continued talking, providing much more information than in the beginning. This method was very helpful, in a sense that it is neutral and I, as an interviewer, did not say anything or ask additional questions, thus ruling out the possibility of my influencing the respondent’s answer. At the same time the respondent provided more in-depth and detailed information.

Another method that I often used during the interviews was an ‘echo probe-’, a very neutral and less risky method which does not change the direction of the interview. In such cases, when my respondents finished their answers to any of the questions, and I still was not satisfied with their answer, I carefully repeated the last phrase said by the interviewee. In most cases the respondent returned to the last topic of the conversation and elaborated on it, thus providing more comprehensive information.

I used the third method – the ‘statement probe’ method – during interviews with females with drug use problems. This methodology is especially used when talking about sensitive and taboo issues, when respondents feel awkward or do not want to talk at all. While asking women respondents about their experiences, fears and family situation, I often had to resort to this technique - that is, I acted as if I

²⁰³Gordon, R. (1992). Basic Interviewing Skills. Chapter 9, Probing the Response for information, Ithaca: Peacock, pp-145-165.

already knew everything that was related to that subject and I started talking about ‘hidden’ or ‘forbidden’ details of the subject without any hesitation or insinuation. This technique made the respondents feel that everything was already known and so there was nothing to hide about the issue, leading to them becoming more open and offering many more details than they perhaps would have done otherwise. However, the ‘statement probe’ method requires the most caution, because the openness of the respondent increases the responsibility of the interviewer in order that the respondent does not regret later agreeing to the interview. Despite the fact that this method may be very effective, I always tried to think about the respondents’ interests, so that I did not violate elementary ethical norms.

The Fieldwork

Professionals in the drug rehabilitation field

The fieldwork was divided into two phases. The first phase implied conducting in-depth interviews with drug rehabilitation professionals (psychiatrists, psychologist, psychotherapists, Social Workers, Scientists and Doctors working in the drug rehabilitation clinic, researchers working on drug use and prevention issues, and representatives of NGOs involved in harm reduction activities). The expert interviews were exploratory, aiming to gain insight into experts’ perceptions and understandings of the drug related issues in Georgia. The main ideas behind studying experts was first to find out whether they acknowledged gender differences: a) in the reasons for drug use, b) in the problems faced by drug users and c) in treatment needs, and second, to reveal problems connected with male and female drug use and find out what solutions experts could offer.

In order to study experts’ opinions, I interviewed 20 experts in Tbilisi specializing in the field of drug addiction. I used a purposive sampling method²⁰⁴ to approach my study participants. I applied to the local NGO ‘Foundation Global Initiative on Psychiatry-Tbilisi,’ an organization actively working on drug prevention strategies. From the list of professionals that the representatives of the organization provided to me I selected 30 individuals working on drug-related issues in Tbilisi and other cities of Georgia. I selected the experts who met the following criteria: had at least 7-10 years’ experience working on drug issues, had a good understanding of the situation in Georgia, were familiar with drug policy, and had experience of working with women with drug use problems. At first I selected 30

²⁰⁴ Purposive Sampling as a Tool for Informant Selection. Available at: <http://scholarspace.manoa.hawaii.edu/bitstream/handle/10125/227/11547-3465-05-147.pdf>, Accessed: 29.09.13.

respondents who met the above-mentioned criteria and started contacting them by telephone and mail. From those 30 individuals 20 agreed to participate in my study. From the 20 selected experts 12 were women and eight were men. From eight male experts **three** were professors, working at the Institute on Addiction as doctors, involved in detoxification and methadone therapy. **Two** other male psychiatrists were working in the Medical Center Uranti which has detoxification and methadone substitution programs. The remaining **three** male experts represented NGOs involved in harm reduction activities (one of the experts was director of Georgian Harm Reduction Network, another was director of NGO ‘New Vector,’ and the third worked in decision-making positions in the Georgian Harm Reduction Network). All were actively engaged in rehabilitation as well as prevention activities, were residents of Tbilisi, and were working in Tbilisi.

Table 1. Information about the Experts

N	City	Gender	Age	Profession	Work Place	Respondent Code
1	Tbilisi	Male	70<	Professor/ Narcologist	Research Institute on Addiction	R20
2	Tbilisi	Male	45-55	Professor/Narcologist	Research Institute on Addiction	R19
3	Tbilisi	Male	35-40	Professor/Narcologist	Research Institute on Addiction	R17
4	Tbilisi	Male	50-55	Psychiatrist	Medical Center Uranti	R3
5	Tbilisi	Male	30-35	Psychiatrists	Medical Center Uranti	R6
6	Tbilisi	Male	40-45	Medical Doctor/Director	Georgian Harm Reduction Network	R7
7	Tbilisi	Male	45-50	Director	New Vector	R2
8	Tbilisi	Male	35-40	Researcher	Georgian Harm Reduction Network	R10

From 12 female experts **nine** were residents of Tbilisi, **two** were from Zugdidi, and **one** from Gori. From nine female experts in Tbilisi **three** were psychiatrists working in the Research Institute on Addiction, **two** were psychotherapists specialized in drug addiction issues having their own private practice, **one** was a social worker working in medical center Uranti with patients from a methadone program, **one** was the director of non-governmental organization ‘Kamara’ providing psychological

and rehabilitation services, and a further **two** represented an NGO involved in harm reduction activities. All three experts from Gori and Zugdidi (one expert from Gori and two from Zugdidi) represented NGOs involved in harm reduction activities ('Step to the Future' in Gori and 'Xenoni' in Zugdidi). All three female experts were working in leading positions, had primary contact with beneficiaries with drug use problems, and were also engaged in research activities. Times for the interviews were arranged with experts in advance and each interview was conducted at their workplace, with a full guarantee of confidentiality. Only those interviews that were held with experts from regions – Gori and Zugdidi - were conducted at my workplace, as those experts were on a short business trip to Tbilisi and so were able to meet and be interviewed during their stay. Each interview followed a pre-prepared open-ended discussion guide and was recorded on an audio recorder. The open-ended questions encouraged my respondents to provide more information, express their feelings and attitudes and to present their understanding of the subject, giving me an opportunity to better access the experts' true understandings and opinions on the drug use issue.

Table 2. Information about the Experts

N	City	Gender	Age	Profession	Work Place	Respondent Code
1	Tbilisi	Female	40-50	Psychiatrist	Research Institute on Addiction	R13
2	Tbilisi	Female	40-50	Psychiatrist	Research Institute on Addiction	R5
3	Tbilisi	Female	35-40	Psychiatrist	Research Institute on Addiction	R15
4	Tbilisi	Female	50<	Psychotherapist	Private practice	R4
5	Tbilisi	Female	55<	Psychotherapist	Private practice	R1
6	Tbilisi	Female	25-30	Social Worker	Medical Center Uranti	R8
7	Tbilisi	Female	40-45	Psychologist	Director of Kamara (NGO)	R18
8	Tbilisi	Female	35-40	Researcher	Alternative Georgia (NGO)	R9
9	Tbilisi	Female	25-30	Counseling Specialist	Georgian Harm Reduction Network	R11
10	Zugdidi	Female	45-50	Psychologist	Xenoni (NGO)	R12
11	Zugdidi	Female	30-35	Social Worker	Xenoni (NGO)	R14

12	Gori	Female	45-50	Counselor /Epidemiologist	Director of organization - Step to the Future (NGO)	R16
----	------	--------	-------	------------------------------	--	------------

The interview guide included discussion topics about the general situation regarding drug use and legislation in Georgia; different causes of drug addiction; the age at which people most often begin experimenting with drugs; the frequency of drug addiction in women; the differences between male and female drug use complications and problems; personal attitudes towards males and females with drug use problems; how the treatment process is structured; what problems patients face during treatment; what barriers individuals with drug use problems encounter from society and in everyday life; and what individual or social factors hinder successful implementation of treatment (see detailed discussion guide in Annex 1).

One point which should be taken in to the consideration is that while talking about individuals with drug use problems, all experts focused on individuals aged from 20 to 55 with severe drug dependence and explored different examples of people who belong to the above-mentioned group. The experts did not talk about users of marijuana and/or ecstasy in clubs and entertainment situations who do not have severe dependence problems. The average duration of each interview was 40-45 minutes. Each interview was subsequently transcribed and used as a basis for the analysis presented in the next chapter. After the first findings obtained from experts' interviews had been summarized, I came to the conclusion that more in-depth information was needed on some topics and issues which I had not addressed earlier. Despite the fact that I got comprehensive information from experts' interviews, some topics and issues (for example the reasons and motivations for women to use substances, stigma and women, gender approach while working with women, etc.) needed more clarification in order to avoid some misconceptions during the analyses.

Therefore, I approached again some of the experts who had participated in my study. For the second interview I selected only those eight experts whose previous interviews raised the necessity of clarification and more in-depth explanations. From these eight experts five were females (two psychologists from Tbilisi, two NGO representatives from Zugdidi and one NGO representative from Gori) and three were males (one psychiatrist working in the Institute on Addiction, one psychiatrist working in clinic Uranti and one representative of NGO 'New Vector' involved in harm reduction activities). The second round of interviews was also conducted with the previous discussion guide, but I only dealt with the issues that needed clarification. The second round of discussion was more

purposeful. The average duration of each second interview was approximately 20 minutes. The interviews with male and female experts from Tbilisi (five interviews) took place at their workplaces. One interview with the female expert from Gori was conducted at my workplace and two interviews with experts from Zugdidi were conducted via Skype. All eight interviews were transcribed, the information was summarized, combined with the first draft of expert interviews summary, and analyzed.

Qualitative research instrument: A discussion guide for in-depth interviews with respondents with drug use problems

To achieve the afore-mentioned goals of my study, the next step I took was to create a discussion guide for the interviews with individuals who have drug dependence problems. The literature analyses and expert interviews outlined a great deal of important topics and issues which had to be addressed during the interviews with individuals with drug use problems. Accordingly, I decided that the open-ended discussion guide had to contain discussion topics such as situations in which the first drug use happened, respondents' feelings and emotions towards themselves and others who use drugs, problems they face in everyday life, attitudes towards society, family members and loved ones, the importance of treatment and healthy lifestyle, motivations and desire to change their life, etc. (see detailed discussion guide in Annex 2).

After giving the interview guide its initial draft form and including in it eight discussion topics, I decided to test it by conducting four pilot in-depth interviews with my friends and acquaintances who had some experience with drug use. The pilot in-depth interviews aimed at achieving the following goals:

1. To correct and finalize the interview guide;
2. To determine the degree of clarity of the questions in the interview guide;
3. To determine how this or that question should be formulated;
4. To remove unnecessary questions;
5. To add topics that the respondents will touch on during the discussions and those that are important for studying the afore-mentioned issues;
6. To get an approximate idea of which issues respondents will find it easy and/or difficult to talk about.

The pilot study showed that the interview guide included too many questions and topics for discussion and it was necessary to narrow the topic and to use a conversational style during the interview. The guided interview included too many structured and concrete questions, therefore, it was hard to ensure a comprehensive discussion and the respondents tended to give short and concrete answers. I came to a decision that it was necessary to reconstruct the discussion guide with the thought of a conversation in mind rather than interview questions; to include topic questions with areas for prompting rather than exact questions. The above-mentioned changes helped me to get more reflections on different issues regarding the research aims and ensured a more flexible and honest discussion.

The final version of the discussion guide focused on drug use patterns, trends, motives and reasons behind the individual person's drug behaviour. The questions were formulated in such a way that encouraged the respondents to reveal their feelings, understandings, emotions, expectations, attitudes and perceptions with regard to drug use and addiction problems. The questions and topics listed in the discussion guide were designed to allow the respondents with drug use problems to convey a situation from their own perspective and in their own words. Each interview started with the same request – asking the respondents to share some information about themselves, and then moved on by asking them to recall the situation in which their first drug use happened. The above question also comprised issues such as: at what age they used drugs for the first time, who the people around them were at that time, where it happened or for what reason, who offered them drugs, who helped them, which group of drugs and how the individual used them. The discussion of these themes shed some light on whether the first use was forced, voluntary, or triggered by conformist or unconscious behavior. With most of the respondents the discussion naturally switched to the next topic where they remembered the situation when they used drugs again and how they developed drug dependence, when and in what situation they discovered that they had gone too far, whether or not they turned for help to anybody.

The discussion guide comprised the issues that were related to the respondents' attitudes toward themselves, society and drug addiction. The conversation about these topics reflected the respondent's attitude and views towards such issues as social rejection, discrimination, stigma, self-stigma and alienation, unemployment, fear of being alone, hiding and making a secret out of drug behavior. Among the topics touched upon during the interviews were various services engaged in activities related to addiction treatment and harm reduction. Talking on these topics allowed me to find out the degree of awareness of the respondents about certain treatment services, and to learn about their experience and attitude towards addiction treatment facilities, doctors and other services.

The questions regarding the respondents' future plans, expectations and wishes focused on issues such as their view of the future, the problems they face and the issues they would like to solve, belief in themselves, and hope for help from the people close to them. The interviews conducted on the above topics allowed me to compare the information, stories and experiences provided by male and female respondents and answer the questions in my study. The general strategy for the interviews I had chosen was to start with broad questions and follow up on the interviewee's responses, to capture her/his meanings and to avoid imposing my meanings on the interviewee and his/her life experiences and world views.

Individuals with drug use problems

At the second phase of the fieldwork, a total of 52 individuals (26 females and 26 males) with drug use problems were sampled in three cities of Georgia (Tbilisi, Zugdidi and Gori). Individuals with drug use problems represent a 'hidden' population, the population wishing to keep its identity secret; stigmatized demographic groups that are difficult to identify using traditional survey methods.

The literature suggests that the most appropriate and most widely used method to access the 'hidden' or hard-to-reach population is a snowball or referral sampling.²⁰⁵ A snowball or referral sampling represents a non-probabilistic sampling technique which gives an opportunity to a researcher to recruit a few initial respondents, who are later asked to refer other respondents within the population.²⁰⁶ This type of technique seemed to me most practical, because in the case of individuals with drug use problems, I needed to identify one or two respondents willing to participate in my study, and then those few respondents would help me to locate others. However, before using the snowball method I had to find those individuals who would participate and then help me find other participants. One problem with the snowball approach which should be mentioned is that the snowballing technique tends to recruit more homogeneous respondents.²⁰⁷ Those respondents who participate in recruitment and try to find available and appropriate people for the study often tend to recruit those whom they resemble in

²⁰⁵For detailed information see: http://marketing.conferenceservices.net/resources/327/3554/pdf/AM2013_0378_paper.pdf, Accessed: 18.10.13.

²⁰⁶Kalton, G. and Anderson, D.W. (1986). "Sampling Rare Populations," *Journal of the Royal Statistical Society, Series A* (General), 149 (1) pp. 65-82.

²⁰⁷Atkinson, R. and Flint, J. (2001). *Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies*, Available at: <http://sru.soc.surrey.ac.uk/SRU33.html>, Accessed: 18.10.13.

age, education, income and other non-heterogeneous characteristics.²⁰⁸ It means that the snowball sampling technique is lacking in diversity because only well-connected, homogeneous respondents tend to be over-sampled and therefore this technique can dramatically reduce the likelihood that the sample will represent a cross-section of the population. In order to increase the sampling diversity, and yield robust and refreshing insights, I set the sampling criteria.

The selection criteria that I devised for my study participants were the following: gender, type of settlement, age and frequency of using illicit substances.

I conducted interviews with 26 women and 26 men, 52 respondents in total. I decided to conduct my study in three cities of Georgia- Tbilisi, Zugdidi and Gori. Tbilisi was selected for its being the capital, while the other two regional cities were selected based on the high proportion of individuals (especially women) with drug use problems, and the experience and practice of organizations which are located in these regional cities and provide drug rehabilitation services. Regarding the age, - the participants of my study had to be at least 20 years old, not older than 60; and had to be residents of Georgia. The last criterion was the frequency of using illicit substances – all the participants had to have used one or more illegal substances during the past 90 days. All participants had to have a severe dependence syndrome. Those who are recreational users and do not have abstinence syndrome tend to be less stigmatized and tend not to account serious problems regarding drug use complications, treatment needs and societal barriers and therefore, such individuals were not eligible for my study.

The knowledge and information gained from the literature analysis and expert interviews helped me to assess the difficulties I would encounter during the research process. I understood well that the stigma, discrimination and criminalized drug policy in Georgia (see detailed information on Georgian Drug Policy in Chapter 3) were main hindering factors on my way to finding and persuading individuals with drug use problems to participate. Severe criminal penalties for drug use, anti-drug campaigns designed to shame users, police harassment and arrest of users tend to drive drug users further underground.²⁰⁹ The negative stigmatized attitudes of society and the fear of being judged, punished and discriminated against seriously affects individuals with drug use problems and results in a desire to remain invisible. And so I was aware that the first difficulty would be not only finding the individuals, but also getting

²⁰⁸Binsardi, A. and Green, J. 2012. “*Research Methods for Management.*” Pedagogic Teaching Series, 2, London, UK, Publisher: Northwest Academic Publications (NAP).

²⁰⁹Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). Drug Situation in Georgia – 2012, Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

individuals with drug dependence to participate in my study. As women represent the major portion of the stigmatized group, the recruitment of women seemed to me the most problematic assignment. However, I decided to solve this issue first and started looking for appropriate women respondents in Tbilisi.

During snowball sampling, the initial number of subgroup members is identified from whom the desired data are gathered and who then serve as ‘seeds.’ The seeds are involved in recruiting other respondents and help to identify other subgroup members. These participants in turn are asked to provide information on other subgroup members, and the process continues until either a target sample size has been reached or the sample members fail to provide information that is new and different from that provided by previous participants. In theory, snowball sampling implies choosing first an initial participant – the ‘seed’ – randomly, However, in practice, and especially in the case of hard to reach populations, this is very difficult or in most cases impossible to carry out. Therefore, as a practical matter, initial seeds in snowball sampling tend to be chosen via convenience or purposive sampling.

I decided to approach the organizations where members of the drug using community could be contacted, such as drug treatment centers and NGOs providing various services for harm reduction, psycho rehabilitation, etc.

Stage I: Sampling process of women with drug use problems

Recruiting of female respondents in Tbilisi

The first step was to approach the Research Institute on Addiction (currently The Centre for Mental Health and Prevention of Addiction).

The Centre for Mental Health and Prevention of Addiction Ltd. is the only institution in Georgia that fully comprises psychiatric and addiction services and conducts activities similar to those recognized and accepted around the globe.

The Centre has psychiatric and addiction in-patient departments (120 beds, including 40 for the addiction department), and a psychiatric and addiction out-patient department where patients with various mental disorders are treated and rehabilitated. At the same time, the center operates a crisis intervention service and out-patient department for children with mental disorders. The center is implementing a substitution therapy program financed by Global Fund. The Centre also operates nine departments for substitution treatment of opioid addicts, where the State Program for Addiction is

carried out. Four of those departments operate in Tbilisi, and five operate in big cities (Telavi, Kutaisi, Ozurgeti, Poti, and Zugdidi) of the western and eastern regions of Georgia. Within the framework of the program, services are rendered to 1200 patients.²¹⁰

As I was familiar with some of the representatives of the institute because they had participated in my expert interviews, I asked them to help me to get in contact with females with drug use problems who might be available for my study.

Two representatives of the Research Institute on Addiction recruited available individuals from their patients. They used purposive sampling, approached those patients who had strong dependence syndrome, aged 20-55, at least secondary or technical education and who had used illicit substances during the past 90 days. Following the listed criteria, the representatives of the Institute on Addiction selected six females from the registered nine females at their Institute; two women refused to participate in the survey but four of them agreed. The representatives of the Institute on Addiction arranged the time for interviews and I met them at the clinic which provided me with a special room for the interview process. I was able to conduct only one interview with a female, however, as the other three females asked me to change the interview time. We exchanged telephone numbers and arranged a new time and place for interviews by telephone. These interviews with females were conducted at my workplace. The age of the selected four women from the Institute of Addiction varied from 21 to 30. Two of the women had secondary education, one had higher education and one had graduated only from school and was not studying at the moment of the interview. Only one had a part time job. Others were unemployed. Three women were married but only one had children. The unmarried female lived with her parents. Three out of the four interviewed women were involved in methadone substitution therapy and one was in a detoxification therapy with short term psycho-rehabilitation at the Institute on Addiction. All four of them received a gift (20 USD incentives) as remuneration for their participation in the study and were asked to serve as ‘seeds,’ that is, to recruit other women with drug use problems for interviews from their acquaintances. However, only one female (aged 21, married, without children) agreed to help me and promised to forward other women who use treatment services at the Institute on Addiction to participate in my study. The other three women refused to help me as they felt too ashamed of their drug complications and tried to conceal their drug use even from others who had

²¹⁰The information about this Center has been provided by its representative in written form. At this point the Center does not have a website from which information could be obtained.

similar problems- they were against letting others know that they had participated in a study about drug use.

I had to decline the offer of a female respondent who offered me her help in the recruitment of other women who were registered at the Institute on Addiction. I understood that, despite the fact that I had met some important selection criteria for participants (such as age, gender and settlement type), by interviewing other patients registered at the Institute on Addiction I would get a homogenous group of study participants – only those who were in treatment at the Institute on Addiction and would miss the opinions and insights of those individuals that were using other services at other institutions or organizations or of those who were not using treatment and/or other rehabilitation services at all.

In order to reach a more diverse group, I had to add one more criterion, namely the type of treatment.

During my sampling I had to find those individuals who were in treatment (methadone substitution program, detoxification, short term or long term psychological rehabilitation - see details about treatment options in Georgia in Chapter 3), those who were not in treatment but who used different services provided by a harm reduction network and those who had never used any treatment or other services. Although the above-mentioned criterion complicated the process of sampling, it increased the chance of getting a diversity of participants who would contribute in creating a more diverse picture. It was understood that I had to find more individuals with drug use problems who would serve as ‘seeds’ and would have broader contacts with people who use drugs and were willing to recruit individuals who met the listed participation criteria. A sampling method I decided to use for the study was Respondents Driven Sampling (RDS)²¹¹ which is very similar to snowball sampling, but differs from snowball sampling in that each respondent has to recruit a fixed number of additional respondents from their network of friends (one recruits two individuals, another one recruits three individuals). In the case of RDS a double incentive system is implemented. Each of the respondents receives incentives both for participation and for each successfully recruited respondent.

In order to find those who would serve as ‘seeds,’ I turned to the representatives of the medical center Uranti who had also been my respondents during the expert interviews.

²¹¹Goodman L. A. (2011). On Respondent-Driven Sampling and Snowball Sampling in Hard-To-Reach Populations and Snowball Sampling Not in Hard-to-Reach Populations. In: Liao Tim Futing., editor. *Sociological Methodology*. vol. 41. Hoboken, NJ: Wiley-Blackwell;

Uranti was created in 2003 in Tbilisi and is focused on treating patients with various addictions (drug addiction, alcoholism, abuse of psychotropic and soporific drugs, gambling). The clinic is actively engaged in a campaign for preventing substance abuse and alcoholism in young people. The clinic provides consultation and treatment services of various specialists besides narcologist's services. It has rooms for each of the following: neurologist, psychotherapist, rehabilitation specialist, transfusiologist, psychiatrist and psychotherapist.²¹²

The representatives of Uranti found two women from their patients who had broad contacts with the drug community and their contacts were not limited only to the clinic patients. Accordingly, these women were suitable for recruiting and for receiving money for the assignment; however, at the last moment they refused to be involved or to help. The reasons for this refusal were the severe stigma and discrimination women with drug dependence feel and the low level of trust towards me. It was hard for them to believe that I was an absolutely independent researcher really working on drug use issues and that I was not representing the police or other law enforcement institutions.

The medical staff suggested that I should visit the Georgian Harm Reduction Network's head office in Tbilisi and ask them for help.

The Georgian Harm Reduction Network was created in 2006. Currently, the network comprises 23 member organizations from nine cities of Georgia. The organizations share the same idea of reducing harm caused by substance abuse and carry out activities such as: identification and treatment of AIDS, hepatitis B, C and other infections transmitted by blood, providing consultations, distributing information materials on safe injection and safe sexual life, influencing state drug policy, advocating rights and strengthening the community, protecting the rights of female substance abusers, preventing overdose, and facilitating the organizational growth of member organizations. The Georgian Harm Reduction Network is actively engaged in: changing the Georgian drug policy direction from an approach that implies strict, full abstention into harm reduction. The Harm Reduction Network serves about 3,500 – 4,000 visitors a month. Apart from the sterile injection equipment, beneficiaries are examined for AIDS, hepatitis B, C and syphilis, are given informative and educational materials on drug related harm reduction, and are provided with Naloxons to be used in the case of opioid drug overdose. The centers provide all services free of charge and protect the beneficiaries' anonymity. As of 2012, the demand for services is as follows: about 800 beneficiaries at the two centers in Tbilisi

²¹² See details about the medical center at: <http://www.vipmed.ge/uranti/>, Accessed : 13.06.14.

during one month, 400 in Gori, from 300 to 350 in Batumi, 300-350 in Zugdidi, 200 on average in Samtredia, about 250 in Kutaisi, 350 in Telavi, and around 300 in Sokhumi.²¹³

During my visit to the office of the Harm Reduction Network, I was introduced to one female ex-drug user, who was using a variety of services at harm reduction network and who also assisted the harm reduction network staff. As an ex- user she had broad contacts with the drug using community, was trusted and respected by the community, and was working as an ‘outreacher’ providing the Harm Reduction Network with various beneficiaries.

I explained to her the aims and objectives of my study and introduced her to the selection criteria for recruiting women with drug use problems. She was glad to help me and assured me that she would provide me with women respondents. During a one month period, the ‘outreacher’ selected appropriate females, made a schedule for an interview with each and took care to ensure that the respondents arrived for the interview at the appointed time and place. From the recruited seven women, only three agreed to participate. Their age varied from 32 to 55; one was married with two children, another was widowed without children, and the other was unmarried. None of them was employed. Two of the three women had higher education and one had a technical education. One was a beneficiary of the Harm Reduction Network and the other two had never used any treatment or rehabilitation services. All three interviews with these women were conducted at the office of Harm Reduction Network as the environment and situation their made the women feel safe and confident. All three females with drug use problems received a gift (20USD) for participating in my study and were asked to find appropriate women from their drug using acquaintances and were offered extra money for that assignment (10 USD for each successfully recruited participant). Each of the women provided me with further respondents, in total five females, with drug use problems. One of the five respondents was involved in Suboxon substitution therapy,²¹⁴ was 22 years old, had higher education and was unemployed and

²¹³See details about the Georgian Harm Reduction Networks at:

http://www.ziani.ge/index.php?item_id=0&component=SUB_MENU&menu_id=1&sub_menu_id, Accessed: 16.06.14.

²¹⁴Suboxone is an opioid medication which contains a combination of buprenorphine and naloxone and is used to treat narcotic (opiate) addiction. Buprenorphine is a partial opioid agonist, which causes it to be less addictive than either heroin or methadone. The “high” produced by buprenorphine is less intense, and the side effects are less dangerous. In general, buprenorphine is safer than methadone and it is easier for a patient to discontinue buprenorphine than to detox from methadone. Suboxone is prescribed at the time of opioid substitution therapy. It helps reduce opioid abuse, and makes it easier for patients not to abandon treatment. Patients no longer desire opioids and do not experience opioid withdrawal symptoms. Suboxone helps preserve a patient’s psychic condition and keeps them alert.

unmarried. Two of them (aged 35 and 27) were involved in the methadone substitution program at the Uranti clinic, both were married (only one had a child), unemployed and had a technical education. And the other two women (aged 34, 53) were unmarried, with higher education, and unemployed, One of them had never used any treatment or rehabilitation services and the other one (aged 34) was involved in a long term psycho rehabilitation program at NGO ‘Kamara.’

In 2011, the non-governmental organization Kamara, with the financial support of the Open Society Georgia, founded a Psychosocial Rehabilitation Center. The Center aims to maximize the rehabilitation effectiveness of substance-dependent individuals and ensure their reintegration into society. The Center provides patient-oriented therapy with eight different psychotherapy modules. It runs group and individual therapy courses which use a psychosocial rehabilitation method created by an American psychiatrist for substance-dependent individuals. In the US the method is also regarded as one of the most complete and correct treatments. This method turned out to be ideal for the current situation and patient in Georgia. So far, Kamara is the only psychosocial rehabilitation center, which provides patients with intensive and complex therapy, and keeps them under intensive psychiatric and psychological observation. All patients enrolled in the program have shown better-than-expected positive results. As of today, 120 patients have completed rehabilitation treatment in Kamara.²¹⁵

All the interviews, except for the first four interviews which I conducted with the selected respondents from the Institute on Addiction and one interview with the beneficiary of NGO ‘Kamara,’ were held at the head office of the Georgian Harm Reduction Network, with full observance of confidentiality. Overall, I interviewed 12 women with drug use problems in Tbilisi. All respondents received incentives (gifts) for their participation and those who also provided me with other participants received a sum of 10 USD for each person. The interview data were transcribed and summarized. The average duration of each interview in Tbilisi was approximately 60 minutes. All the interviews in Tbilisi were recorded using a digital recorder.

When all the interviews with respondents in Tbilisi were done, I started to listen to the audio recordings and transcribe them in detail. While listening to the recordings I also made comments regarding the topics and questions which needed more clarification and in-depth information. I made a list of those

See details about suboxon substitution therapy at: <http://www.treatmentsolutions.com/the-debate-over-drug-abuse-treatment-methadone-vs-buprenorphine/>, Accessed: 16.06.14.

²¹⁵The information was provided by a representative of the organization. The organization does not have a website.

six respondents who had to be interviewed for a second time. I also marked those questions which I had to ask them again and listed some new questions which were important to be acknowledged. In a few weeks, with the help of the same ‘outreacher’ who had helped me before, I met the three women whose answers given during the earlier interviews needed more clarification. I found the other three women independently- I managed to get their telephone numbers and/or Facebook contacts. Only four of them agreed to participate in the second round of interviewing process and all four interviews were conducted at my workplace. The interviews were much shorter, containing only a few issues for discussion and a few thematic follow up questions. All four interviews were recorded and afterwards transcribed; the information was summarized, combined with the first draft of the interview transcripts and summarized.

Table 3. Recruited female respondents in Tbilisi

N	City	Gender	Age	Marital Status	Type of Treatment/Service for Drug Addiction	Respondents Code
1	Tbilisi	Female	21	Married	Research Institute on Addiction → Methadone substitution therapy	R 1
2	Tbilisi	Female	24	Single	Research Institute on Addiction → Methadone substitution therapy	R 2
3	Tbilisi	Female	27	Married	Research Institute on Addiction → Methadone substitution therapy	R 3
4	Tbilisi	Female	30	Married	Research Institute on Addiction → Detoxification therapy	R 4
5	Tbilisi	Female	32	Married	Harm reduction Network	R 5
6	Tbilisi	Female	41	Single	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 6
7	Tbilisi	Female	55	Widowed	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 7
8	Tbilisi	Female	22	Unmarried	Research Institute on Addiction → Suboxon substitution therapy	R 8
9	Tbilisi	Female	27	Married	Medical center Uranti → Methadone substitution therapy	R 9
10	Tbilisi	Female	35	Married	Medical center Uranti →	R 10

					Methadone substitution therapy	
11	Tbilisi	Female	34	Unmarried	Nongovernmental organization Kamara → Psychological rehabilitation services	R 11
12	Tbilisi	Female	57	Unmarried	had once used detoxification treatment in the past	R 12

Recruiting of female respondents in Gori and Zugdidi

In order to include women with substance use problems from the other two cities of Georgia (Zugdidi and Gori) I employed the same first step of asking my interviewee experts from the cities for help. At first, I approached the director of a non-governmental organization ‘Step to the Future’ in Gori (she had been my respondent during the expert interviews) and asked her to help me to recruit women according to my sampling criteria.

The non-governmental organization Step to the Future has been operating in Gori since 2006. It is a member of the Georgian Harm Reduction Network. The main goals of the organization are the establishment of a healthy lifestyle within society, raising public awareness about avoiding drug dependence and other associated infectious diseases. The organization is also actively engaged in HIV/AIDS prevention, social rehabilitation of persons suffering from AIDS and other substance-dependent persons and their protection from discriminatory treatment. Since 2007, the organization has carried out AIDS prevention activities with risk groups of the population within the framework of the program Global Fund ‘Enhancing the national response in Georgia for prevention and control of HIV/AIDS.’ The organization has two centers: in Gori and Telavi, serving 2,000 beneficiaries.²¹⁶

The director of Step to the Future agreed to help to find females with substance use problems from the beneficiaries of their organization and also to involve the beneficiaries in the recruitment of other individuals.

During a one week period the director of Step to the Future organized the recruitment of women with substance use problems. According to our agreement, the director recruited two women with substance use problems living in Gori who were the primary beneficiaries of the organization, and these two women were involved in Respondents Driven Sample. They in turn recruited four additional women.

²¹⁶This organization does not have a website and the information about the organization was provided in written form by its director.

From these four women only one was involved in Respondents Driven Sample, and she recruited one additional respondent. Overall, seven women were recruited and involved in the study in Gori. The age of the selected respondents varied from 26 to 50 and all of them were unemployed. Only one of the respondents, aged 29, had received complete higher education, while the others had secondary education. Most of them (5) were married and had children. The married women lived together with children and spouses either at their own flats or with their parents-in-laws'. Two of these women had used some treatment services for drug use and three of them had never been in treatment at all nor had they used harm reduction services.

All interviews with these selected women were conducted at the office of Step to the Future. In all cases the respondents found it difficult to talk and discuss the issues and topics listed in the interview guide. Unlike the interviews conducted in Tbilisi, the interviews with respondents from Gori took much more time and energy. The average duration of each interview was 80-95 minutes and the questions needed to have more follow-up questions and had a more structured nature. Although most of the women preferred to receive incentives in cash, I was unable to use cash due to local regulations and therefore I distributed vouchers (worth 20 USD) for purchases at a local grocery store as remuneration for their participation in the study. After each interview was recorded, I started the transcribing process and made notes and remarks regarding some answers, listed some questions that had to be clarified and outlined some important questions that had to be addressed. By the time all seven interviews with women with substance use problems living in Gori had been finished, I had detailed transcripts and notes about what had to be clarified and who had to be interviewed for a second time. Due to the fact that the female respondents from Gori were less likely to talk about their problems, a great deal of answers given by my respondents seemed shallow and too general for me. Despite the fact that I had tried to do my best during the interviews, I had received superficial data and I was not satisfied. Therefore, I decided to meet some of the women again hoping to receive more in-depth information. However, I had no guarantee that I would receive any more honest or realistic answers the second time. It was obvious that these women had a problem trusting me. I was received as an outsider from their group, and there were two reasons for that: I was not using drugs and so was obviously distanced from their problems, and the second reason was that I was from the capital of Georgia- from a big city and, for women living in a small regional town, it was quite uncomfortable to talk on very sensitive and private issues related to their lives. The reason they agreed to participate was very simple; they were interested in the incentive which I was offering, but due to the fact that I was forbidden to use cash incentives, they were disappointed when they received vouchers and not cash.

In order to get more trustworthy and realistic answers, I decided that it would be more appropriate to find someone who was trusted and respected by them and to whom they would give honest answers and would talk openly about their problems, complaints, lifestyle, plans, and perceptions regarding different issues listed in the discussion guide. The director of the NGO ‘Step to the Future’ offered me her help in this regard and agreed to approach these seven women for the second time. During the second round of interviewing process the NGO director only addressed those discussion issues and questions that needed more clarification or had not been answered during the first interviews. In order to motivate these women to participate for a second time, we asked them to tell us what they preferred to receive as remuneration (10 USD) for their time and participation. Each woman had different preferences- like childcare items, body care products, or vouchers for free transportation. The interviews were recorded on a digital recorder and all the recordings were transcribed by me. The second round of interviews was much more successfully accomplished and the data obtained from the transcripts were much deeper, more realistic and richer.

Table 4. Recruited female respondents in Gori

N	City	Gender	Age	Marital Status	Type of Treatment/Service for Drug Addiction	Respondents Code
1	Gori	Female	26	Married	Non-governmental organization “Step to the Future,” harm reduction services	R 1
2	Gori	Female	29	Married	Non-governmental organization “Step to the Future,” psychotherapy	R 2
3	Gori	Female	27	Single	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 3
4	Gori	Female	30	Married	Used detoxification service in public hospital	R 4
5	Gori	Female	39	Married	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 5
6	Gori	Female	44	Married	had never used any treatment/rehabilitation	R 6

					or other services for drug addiction in her life	
7	Gori	Female	50	Widowed	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 7

In order to avoid complications during the interviews with female respondents in Zugdidi, I decided to meet a representative of Zugdidi non-governmental organization ‘Xenoni’ to discuss the problems and challenges encountered during the previous interviews with women.

The association of young psychologists and doctors “Xenoni” is a non-governmental organization established in July 30, 2004 in Zugdidi. Its mission is to promote the improvement of the physical and psychological health of the population. Since July 30, 2004 the organization has carried out more than 20 projects for the reduction of harm caused by drug abuse. Since 2005, Xenoni has been implementing the project of the Global Fund – II components (I lot): ‘HIV/AIDS prevention in injective drug users.’ It actively advocates the rights of and availability of healthcare services for drug-dependent individuals and is one of the first to create women-oriented model services in Georgia, starting to work at different levels to increase the availability of hepatitis C treatment and diagnostics in the country.²¹⁷

The representative of “Xenoni” had also been my respondent during the expert interviews and was well informed about the aims of my study. They suggested that I should use their organization help and let them conduct the interviews with women as well as with men. In order to monitor the process of the interviews, I asked her to organize a meeting with her colleagues from Zugdidi to discuss the interview guide, discuss problems, and to plan the interviewing process. During the joint meeting I shared my experience of the interviews in Gori, explained the problems with women regarding the fear and distrust towards me, explained the criteria for sampling, and together we overviewed the discussion guide- discussing and analyzing it question by question, explaining what was implied by each particular question, what was my aim, what kind of information I wanted to obtain and how to conduct the interviews. The representative of Xenoni was a psychologist and her two colleagues were social workers, well trained and experienced in conducting face to face interviews with members of the ‘hidden population.’ During a two week period Xenoni representatives recruited three women (aged 27,

²¹⁷This organization does not have a website and information about the organization was provided in written form by its director.

34 and 42) with substance use problems who were suitable for my study and recorded interviews with them. All of these selected women were unemployed housewives, married with two or more children, and lived together with their families in Zugdidi. Two of these women had higher education, one had secondary education. All three were primary beneficiaries of Xenoni and were using psycho rehabilitation and harm reduction services. Two of these three women agreed to be involved in respondent-driven sampling and served as study 'seeds,' recruiting an additional two women, who then, in turn, recruited two more. For the recruitment and for each successfully recruited participant, the 'seeds' were offered 10 USD. Overall, four women with substance use problem were recruited via RDS sampling. All four women were unemployed and had never used any treatment or rehabilitation services. Their age varied from 30 to 40 and most of them were married, living with their family and children together. Only one of these women had higher education and experience in paid employment in the past.

In order to monitor the whole interview process, after each interview I asked the interviewers to send me the recording immediately. I transcribed the interviews, made notes, and gave immediate feedback to the interviewer. We arranged meetings or Skype calls and I explained what and how to improve the discussion, how to guide the discussion, and what to ask again. In order to make use of time and money, I asked the colleagues in Zugdidi to make an agreement with female respondents so that they would participate more than once in the interview if needed. The interviewers explained to the respondents the need for multiple interviews during the study and asked them to participate for the second time and granted them an incentive (worth 30 USD). In order to avoid disappointment and complaints regarding the content of incentives, we asked the respondents to make a list of their preferences (worth 30 USD) and to provide us with this information in advance. While listening to the recordings it was obvious that those women with drug use in Zugdidi trusted the interviewer but still found it difficult to talk openly. Mostly, the women had difficulty in forming sentences or meaning and jumped from one story to another. However, the experienced interviewer managed to coordinate the discussion and to concentrate on those things and issues which were less clear in the respondent's story. All the first round interviews with female respondents in Zugdidi were conducted during the two week period. The following 10 days were dedicated to the second round. In some cases (only in cases of two respondents) a third interview was needed. After each interview had been finished, I transcribed the data, made comments and summaries, and after each successive interview I added, combined and enriched my findings with new and fresh information.

The sampling, recruitment and interviewing of women gave me a lot of experience, and the second phase – finding and interviewing men was much more structured and well organized.

Table 5. Recruited female respondents in Zugdidi

N	City	Gender	Age	Marital Status	Type of Treatment/Service for Drug Addiction	Respondents Code
1	Zugdidi	Female	27	Married	Non-governmental organization “Xenoni” → Psycho- rehabilitation and harm reduction services	R 1
2	Zugdidi	Female	34	Married	Non-governmental organization “Xenoni” → Psycho- rehabilitation and harm reduction services	R 2
3	Zugdidi	Female	42	Married	Non-governmental organization “Xenoni” → Psycho-rehabilitation and harm reduction services	R 3
4	Zugdidi	Female	30	Married	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 4
5	Zugdidi	Female	33	Single	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 5
6	Zugdidi	Female	36	Married	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 6
7	Zugdidi	Female	40	Married	had never used any treatment/rehabilitation or other services for drug addiction in her life	R 7

Stage II: Sampling process of men with drug use problems

Male respondents eligible for my study in all three cities (Tbilisi, Zugdidi and Gori) were sampled via RDS. Initially, drug rehabilitation experts helped me recruit respondents, who then served as study ‘seeds’ who were given a fixed number of individuals they had to recruit from among their friends and

community circle; the recruits needed to meet the selection criteria for my study. All male participants were told in advance that the interviewing process implied their participation more than once. All participants listed their preferences regarding the incentives (worth 30 USD) and received them immediately after the first interview had been finished. Those study participants who served as ‘seeds’ received an additional 10 USD for each successfully recruited participant.

Recruiting of male respondents in Tbilisi

In order to find the first male respondents in Tbilisi, I turned to the Institute on Addiction again. The representatives of the Institute on Addiction found two male patients using detoxification services at their institute and willing to participate and also to help in recruitment.

I arranged a meeting with both of the men (28 and 31 years old, with higher education, unmarried, unemployed, living with parents and using detoxification services at the Institute on Addiction) at the Institute on Addiction in a room provided for our meeting. Each interview lasted approximately 65 minutes and both of them agreed to be involved in RDS and to refer further individuals who used drugs, but who had never been in treatment and had never used any harm reduction services at all. During the 10 day period both male ‘seeds’ provided me with three individuals from their friends circle. The age of the new participants varied from 21 to 45; one of the participants (aged 21) was studying at the technical university and was living with his parents, another one (aged 29) was employed at a private organization owned by his relatives and lived alone with his girlfriend renting a flat. And the third one (aged 45) was divorced, with one child, unemployed, with higher education, without his own flat and income, living with his relatives. After having recorded five interviews, I transcribed the data and was satisfied with the content, clarity and depth of the information. It was obvious than male participants in Tbilisi were much more open, had less problems in talking about and sharing their drug experience with me. However, none of them, due to some circumstances, was able to serve as a ‘seed’ at that moment and I had to find new individuals with drug problems to interview.

I approached non-governmental organization ‘Kamara’ which provides various psychological consultations and services for individuals with drug use problems. I asked the director and other representatives of this organization to help me in contacting one or two of their beneficiaries who have interest in participation and in receiving money. Based on an advance agreement, representatives of the organization singled out those individuals from its beneficiaries who fitted the selection criteria and selected four men with drug use problems. The representatives arranged a meeting for me with those

individuals and I familiarized each pre-selected individual with the aims of the study. Only two individuals were unemployed; one, aged 33, with higher education; and the other one, aged 37, with secondary education. Both were married with children and lived in rented apartments at someone else's expense). The two of them expressed a wish to participate and be involved in the RDS. I arranged the time for an interview, and the interviews were conducted with the full observance of confidentiality at the office of Kamara, in a room allocated for interviews.

After the interviews had been recorded, these individuals, in turn, were asked to refer other additional participants. Three additional males with drug use problem were found and interviewed. The interviewed men were aged 27 and 33, unemployed, unmarried, and had never used any treatment or harm reduction services. These three interviews were also conducted at the Kamara office, in a room allocated for the interviews, the average duration of which was 80-90 minutes. Overall, 10 male participants with drug use problems were successfully recruited and interviewed in Tbilisi. Four participants were recruited via purposive sampling from the beneficiaries of Kamara, and from the patients of the Institute on Addiction, and six participants were recruited via RDS.

After all the interviews had been transcribed, I made comments, summarized the data and realized that I needed to interview some respondents again. I reached one man from the two respondents selected via the help of the organization Kamara and two men recruited via RDS and asked them to answer several questions and discuss some issues given in my discussion guide, again. The second round of interviews was much shorter, in one case it lasted 20 minutes, in two other cases approximately 35 minutes. The second round gave more clarity and depth to the information provided by the participants. I combined the data from the first round interviews with that of the second round of interviews and made summaries.

Table 6. Recruited male respondents in Tbilisi

N	City	Gender	Age	Marital Status	Type of Treatment/Service for Drug Addiction	Respondents Code
1	Tbilisi	Male	28	Single	Research Institute on Addiction → Detoxification therapy	R 1
2	Tbilisi	Male	31	Married	Research Institute on Addiction → Detoxification therapy	R 2
3	Tbilisi	Male	21	Single	Medical center Uranti → Methadone substitution therapy	R 3
4	Tbilisi	Male	29	In a	Medical center Uranti →	R 4

				relationship	Methadone substitution therapy	
5	Tbilisi	Male	45	Divorced	Was using harm reduction services	R 5
6	Tbilisi	Male	33	Married	Non-governmental organization “Kamara” → Psychological rehabilitation services	R 6
7	Tbilisi	Male	37	Married	Non-governmental organization “Kamara” → Psychological rehabilitation services	R 7
8	Tbilisi	Male	27	Unmarried	had never used any treatment/rehabilitation or other services for drug addiction	R8
9	Tbilisi	Male	29	Unmarried	had never used any treatment/rehabilitation or other services for drug addiction	R 9
10	Tbilisi	Male	33	Unmarried	had never used any treatment/rehabilitation or other services for drug addiction	R 10

Recruiting of male respondents in Gori and Zugdidi

In Gori and Zugdidi 16 male individuals (eight male respondents in each city) with drug use problems participated in the study. In Gori, two males were selected via the purposive sampling method among the beneficiaries of organization ‘Step to the Future.’ Both were unemployed, with secondary education, one was divorced (aged 44) and had two children, another one was single (aged 25). Both lived in their own apartments and were using drugs at that time. Both of these interviews were conducted on the same day at the office of Step to the Future and both of participants served as initial seeds who recruited two additional individuals. The selected individuals were aged 56 and 33, both were unemployed, one had completed and another had not completed higher education. Neither of them concealed the fact that they had taken drugs before meeting with me, feeling that, otherwise, they would have been unable to talk to me. The average duration of the interviews with these individuals was 30 minutes, after which both asked me to stop the interview and promised to come for a second time. They also promised to refer other community members to me. In a few days only one (aged 33) agreed to continue the interviewing process. We met each other at the office of Step to the Future and

despite the fact that he had discussed some issues during our first interview, I asked him to answer some questions again and to provide we with more in-depth information. After receiving the 30 USD incentive, he expressed a desire to recruit some respondents for me and managed to do so. During the one week period I was able to find and involve five males eligible for my study. The selection of these five men was conducted via the snowballing method; all the respondents referred other respondents from their drug community. Four out of the five males were unemployed; the majority of them were married, had children and were living with their parents or with parents in law. Three of them had secondary education while two had technical education. Three of them had never used any treatment or harm reduction services, one of them was an ex-methadone patient and another had been involved in detoxification treatment in the past. The average duration of each interview was 50 minutes, with all interviews being conducted at the office of Step to the Future.’ Each respondent received an incentive as remuneration for participation, except one individual who quit the interview and refused to participate a second time.

Table 7. Recruited male respondents in Gori

N	City	Gender	Age	Marital Status	Type of Treatment/Service for Drug Addiction	Respondents Code
1	Gori	Male	25	Single	Non-governmental organization “Step to the Future”, harm reduction services	R 1
2	Gori	Male	44	Divorced	Non-governmental organization “Step to the Future”, harm reduction services	R 2
3	Gori	Male	33	Married	had used detoxification service at the public hospital	R 3
4	Gori	Male	47	Married	had never used any treatment/rehabilitation or other services for drug addiction	R 4
5	Gori	Male	39	Single	had never used any treatment/rehabilitation or other services for drug addiction	R 5
6	Gori	Male	38	Married	had never used any treatment/rehabilitation or other services for drug addiction	R 6
7	Gori	Male	49	Married	had used methadone substitution therapy in the	R 7

					past	
8	Gori	Male	43	Married	had used detoxification service at the public hospital	R 8

In Zugdidi, representatives of the organization ‘Xenoni,’ in accordance with the criteria determined in the framework of the study, selected three respondents in advance, familiarized them with the aims of the study, and arranged an interview at a time convenient for them. The interviews with the selected individuals were conducted at the office of the afore-mentioned organization with full observance of confidentiality. The average duration of each interview was 40 minutes. All three respondents were married, had two or more children, and lived with their family and children in their own apartments. One of them, aged 29, was employed and the other two (aged 47 and 44) were unemployed. All of them participated in the recruitment process and each recruited five more individuals from their circle of friends for the study. The age of these five additionally recruited respondents varied from 20 to 35. None of them was employed; only three of had higher education and while two of them were married with children, one of them was divorced. Only one of them was using detoxification services at the public hospital; two had used psycho-rehabilitation services; the others had never used any treatment or other services.

Overall, I sampled eight male respondents in Zugdidi (five via snowballing and two via purposive sampling) and conducted interviews. After all the interviews had been finished, I transcribed the data, made notes and asked the representatives of Xenoni to help me interview some of the respondents for a second time. The representatives of Xenoni organized the second round of interviews and the same social workers who had conducted interviews with female respondents reached four respondents for the second time and clarified some issues and topics which lacked in-depth information. The second interview approach was shorter and less time consuming. After this second round of interviewing process, each interview was transcribed and combined with the previous transcripts, then all the information obtained from male respondents was summarized and used as a basis for the analysis presented here.

Table 8. Recruited male respondents in Zugdidi

N	City	Gender	Age	Marital Status	Type of Treatment/Service for Drug Addiction	Respondents Code
1	Zugdidi	Male	29	Married	Non-governmental organization “Xenoni” →Psycho- rehabilitation	R 1

					and harm reduction services	
2	Zugdidi	Male	44	Married	Non-governmental organization “Xenoni” → Psycho- rehabilitation and harm reduction services	R 2
3	Zugdidi	Male	47	Married	Non-governmental organization “Xenoni” → Harm reduction services	R 3
4	Zugdidi	Male	20	Single	had never used any treatment/rehabilitation or other services for drug addiction	R 4
5	Zugdidi	Male	32	Married	had never used any treatment/rehabilitation or other services for drug addiction in	R 5
6	Zugdidi	Male	35	Married	had never used any treatment/rehabilitation or other services for drug addiction	R 6
7	Zugdidi	Male	35	Divorced	detoxification service at the public hospital	R 7
8	Zugdidi	Male	28	Single	had never used any treatment/rehabilitation or other services for drug addiction in	R8

Analysis

It was understood that in the case of qualitative data analyses I would need to very accurately review, summarize and interpret data obtained from my in-depth interviews. In order to organize my data, I used a data coding technique that provides a means to introduce interpretations of the data. I read my data again, demarcated segments within it, and labeled each segment with a ‘code’—a short phrase that suggested how the associated data segments inform the research objectives. After the coding process was completed, I summarized the prevalence of codes, discussed similarities and differences in related codes across distinct original sources/contexts, and compared the relationship between one or more codes. During the analysis procedure I tried to understand the subjective meaning of experiences for the participants, instead of placing those meanings into my own conceptions.

Chapter 3

A Historical Review of Drug Related Affairs in Georgia

Introduction

When thinking and working on the issues of drug addiction, I realized that I could not escape the necessity of describing the local situation in Georgia, as the current situation in Georgia regarding drug policy is radically different from that of European countries, and, accordingly, it is necessary to give a detailed review of what is happening in Georgia today and, more generally, what has happened in the recent period. Therefore, the aim of this chapter is to present an overview analysis of the drug situation in Georgia, in order to describe today's situation in clearer and more understandable terms.

First, I decided to focus on the most important factors, such as:

- a) a historical overview since the time Georgia gained independence;
- b) drug legislation and its weaknesses;
- c) the drug market and artificial scarcity of drugs of the opioid group;
- d) society's attitude to drug addiction and to drug users;
- e) existing treatment services.

A review of these factors and the description of the situation will definitely shed more light on the contents of the information provided by the respondents of my study and will make it possible to understand it better. In the interviews presented in next chapters, individuals with drug problems, both male and female, as well as drug rehabilitation experts, talk a lot about weaknesses at the legislative level, society's wrongful attitude towards the problem, and stigma. For this reason, I consider it very important to explain in the introduction what is happening in Georgia today with respect to drug addiction, in order to better understand the issues touched upon by the respondents, and the meaning behind their answers presented in the following chapters.

Georgia and drug use in the recent past

After Georgia gained independence in 1991, it became embroiled in a number of social, political, and economic problems, among these a dramatic increase in the inflow of drugs on the black market as a result of which the country and its population found themselves facing one of the severest problems.²¹⁸

A public opinion survey on the problem of drug abuse was conducted in 2005 on the initiative and with the methodical guidance of the Council for State Policy on Drug Abuse. The survey was conducted by a structured questionnaire prepared on the basis of the previous qualitative survey; 200 respondents took part in the survey, representing different age groups, sex and place of residence. The results were processed by SPSS. The following conclusions were drawn following the survey: the respondents considered the problem of drug abuse as the second most important problem in the country (unemployment took first place), however, the survey also revealed that society did not have a common view of drug abuse- the priority problem to be decided at state level. When asked what problem has exacerbated in the last year, respondents picked unemployment and drug abuse as their first and second choice. The survey participants did not see addiction as a stand-alone problem, but rather as a problem derived from other problems. It shows that from the respondents' point of view an anti-addiction strategy should have been properly planned. If we do not address the underlying problems, we will not achieve desired results. 93 percent of those surveyed thought that drug abusers are ill, 88 percent - unsuccessful, 83 percent - unhappy, 75 percent - prone to crime and dangerous behavior, and consequently, 77 percent think that they are unacceptable to society. Such results indicate the existence of stigma.²¹⁹

Legal Analysis of the Georgian Drug Policy (2012) shows that drug use, for a very long time, has been regarded more as an offence than a healthcare problem, and that the law imposed both punishment and compulsory treatment on drug users.²²⁰ The afore-mentioned analysis reviews the General Provisions of the Criminal Code that had been in force prior to 1999, and according to which drug use was

²¹⁸Brownfield, W.R. (2006). International Narcotics Control Strategy Report: Volume I: Drug and Chemical Control.

Available at:

<http://books.google.ge/books?id=0jnyNWfuhXYC&pg=PA289&lpg=PA289&dq=INCSR,+2006+Georgia&source=bl&ots=ism8Acb3MA&sig=taEWuZzjOy4j7ZKd5qi6lAfWoN0&hl=en&sa=X&ei=t8g9UfLpCMeiO7HqgIAB&ved=0CGYQ6AEwBg#v=onepage&q=INCSR%2C%202006%20Georgia&f=false>,

Accessed: 11.03.2013.

²¹⁹Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2006). "Drug Situation in Georgia – 2005." Tbilisi, Georgia: Southern Caucasus Anti-Drug Program.

²²⁰Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at:

<http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013.

regarded as an offence dangerous to the public.²²¹ Under Article 252²²² of the Code, within one year of the imposition of an administrative penalty, any purchase and storage of even a small amount of narcotic substance without the aim of selling it, or the use of a narcotic substance without a doctor's prescription was punishable with deprivation of freedom for up to two years, with correctional labor for the same term, or with a fine.²²³

As reviewed in the Legal Analysis of the Georgian Drug Policy (2012), Article 63 of the same Code envisaged compulsory treatment of alcoholics and drug users: if a person who had committed a crime turned out to be an alcoholic or a drug user on the basis of a medical report, he/she was to be sent to a specialized medical/preventive care facility for compulsory treatment.²²⁴ If an alcoholic or a drug user was sentenced to imprisonment, he/she was to undergo treatment while serving the sentence. Illegal preparation, purchase, storage, transportation or shipment of narcotic substances with the aim of selling them was punishable with imprisonment for up to ten years or with confiscation of property.²²⁵

The author of Legal Analysis of the Georgian Drug Policy (2012) argues that although the Criminal Code contained a detailed list of all punitive measures for the use of narcotic substances, according to the information of the World Bank (2012), due to the corruption of Georgia's law enforcement bodies in the 1990s, in most cases such penalties were not imposed. But that did not mean that drug users got away with such offences. To avoid punishment, persons arrested while committing a drug-related offence had to cut a deal instead, after which they were under constant harassment (blackmail, intimidation, and racket) by law enforcement bodies.²²⁶ Not only individuals with drug use problems, but also any member of society could become a victim of such harassment- a common occurrence in the systems of post-Soviet countries. And it is a fact that people implicated in drug-related offences were a source of constant income for the corrupt so-called 'law enforcers.'²²⁷ For example, the US State Department's International Narcotics Control Strategy Report of 2004 describes Georgia's law

²²¹ Ibid.

²²² Decree No. 351 of the President of Georgia of June 4, 1999.

²²³ Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013.

²²⁴ Ibid.

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Ibid.

enforcement agencies as ‘overstaffed, under-equipped, poorly paid, and with a reputation of being highly corrupt.’²²⁸

The problem was not limited to the corrupt system alone. A much more serious danger of the diffusion of drug addiction and the development of irreversible processes in the country was related to Georgian society’s incorrect and distorted attitudes to the problem of drug use and addiction. After the disintegration of the Soviet Union, the country became destabilized, and unmanageable political processes began. Inside the country, a number of political forces were struggling for power and for the redistribution of various political-economic resources. Among them, persons close to the criminal underworld were distinguished by exceptional aggressiveness and influence.²²⁹ Accordingly, in a large part of society, fear and reverence to the criminal traditions and criminal bosses became prevalent.

I am making an assumption that Georgian young men adopted concrete models of the ideology and rules characteristic to the criminal underworld, and a concrete pattern of behavior, specifically, the behavior model of a ‘good guy’ which was based on the laws of the underworld, became automatically embedded in their consciousness. It is commonly known that the criminal underworld has strictly defined unwritten laws and a hierarchy which operates both inside and outside penitentiary institutions.²³⁰ The ‘hierarchy of thieves’ is headed by a ‘thief-in-law’ who wields absolute power, while the so-titled ‘good guys’ – persons following traditions of the thieves – occupy the second level on the hierarchical ladder of the underworld. The people who created role models for the young generation were mainly members of the ‘Mkhedrioni’ paramilitary group.²³¹ Over the course of time, these popular young people with power, who initially fought for Georgia’s independence, got involved in many criminal activities and, oftentimes, were also implicated in drug-related offences.²³² Yet, this only increased their popularity and influence over the young generation. I am assuming that it was Mkhedrioni that contributed most to the creation of the behavior model of the so-called ‘good guy.’

²²⁸The Bureau of International Narcotics and Law Enforcement Affairs of the US Department of State, International Narcotics Control Strategy report of March 2004, Washington.

<http://www.state.gov/j/inl/rls/nrcrpt/2003/vol1/html/29838.htm>, Accessed: July 2012.

²²⁹Nordin, V.D. and Glonti, G. (2006). “Thieves of Law and the Rule of Law in Georgia,” *Caucasian Review of International Affairs* 1 (1). Available at: http://cria-online.org/1_5.html, Accessed: 18.03.2013.

²³⁰Ibid.

²³¹For detailed information, see: <http://en.wikipedia.org/wiki/Mkhedrioni>, Accessed: 24.05.2013.

²³²Ibid.

One of the most desirable attributes under this model, together with many others, was drug use by a ‘good guy;’ moreover, drugs constituted one of the main means of self-affirmation.²³³

Both of the important preconditions for drug use – the desire to use drugs and their availability – were more or less met in the Georgia of the 1990s. Perhaps young men were eager to get as close to the ‘good guy’ model as possible by using drugs. As for the drug market, here as well the situation was quite favorable for those who wanted to buy drugs with narcotic substances being imported from neighboring countries.²³⁴ In this respect, the key role was played by the geographical location of the South Caucasus, which has easy access to the sea, and is seen as a bridge between Europe and Asia.²³⁵ The situation was made even worse by the uncontrolled territories formed as a result of the frozen ethnic conflicts which served as additional gates through which drugs reached the country.²³⁶ Accordingly, we have a picture where the easy availability of drugs and the prevalent mentality created favorable conditions for drug use and for the prosperity of people involved in the drug trade.

The majority of the male respondents I interviewed (see Chapter 5 for more details) first tasted and started to use drugs at the age of 13-15, in the middle of the 1990s when respect for criminal mentality and the image of the ‘good guy’ were prevalent. The majority of the male respondents who took part in the study (see Chapter 5) note that the primary and most important reason for their drug use was the situation and the positive attitude to drug addiction that existed in the 1990s. Accordingly, I assume that the unstable political and economic situation that existed in the country, the strong influence of the underworld, and the wrong role models were some of the strongest catalysts for the diffusion of the ‘epidemic’ of drug addiction.

Changes and challenges on the Georgian drug market

The situation began to change slowly from 2003 when a new government came into power through the Rose Revolution. In the framework of anti-corruption reforms designed to establish order and rule of law, the government started destroying the positive and reverential attitude to drug addiction and the

²³³Kartvelishvili, S. (2013). “Why is it necessary to get rid of the 1990s?” Available: <http://lib.ge/book.php?author=1290&book=9239>, Accessed: 24.05.2013.

²³⁴Gamkrelidze, A., Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2003). “Drug Situation in Georgia – 2003.” Tbilisi, Georgia: Southern Caucasus Anti-Drug Program.

²³⁵Ibid.

²³⁶Ibid.

underworld in Georgian society by forcible means.²³⁷ Of course, these reforms were not implemented overnight, and they were accompanied by a number of negative aspects together with positive.

As described in the Annual Report - Drug Situation in Georgia 2005, in 2004-2005, important changes took place in the structure of the use of opioids in the country.²³⁸ While the changes carried out at the state level resulted in a decrease in the medications of the opioid group, according to the data of the Ministry of Internal Affairs, the use of Subutex R, which is imported from Europe, increased.²³⁹

Subutex (Buprenorphine) is a drug used in many countries throughout the world in parallel with substitution treatment by opioid drug abusers. It is a paradox, but this is the drug which became the greatest problem in Georgia. The Annual Report - Drug Situation in Georgia 2005 explains that Subutex does not find its way into Georgia by lawful means and is not used for medical purposes.²⁴⁰ A huge number of Subutex drugs were once brought into the country by illegal means mainly from Europe where it is used in substitution treatment. Consequently, insufficient control over the medical use of Subutex in some countries made it possible for Subutex to enter the 'black market.' It must be noted that trade in Subutex was a very 'profitable business' because, while in Europe the price of one pill of Subutex was about one euro, in Georgia it would cost up to USD 120-130. The abuse of Subutex attracted the attention of the experts in 2000.²⁴¹

Since then, the illegal abuse of this drug has been on a steady rise, and reached particularly alarming scales in 2004-2005. The Annual Report - Drug Situation in Georgia 2005 demonstrates that one of the indicators of the increase in Subutex R use was the increase in the number of Subutex R users among patients who visited drug treatment institutions. In 2004, 29 percent of those who visited the clinics to alleviate dependence on opioids used Subutex R, while in 2005 the number of such patients reached 39 percent²⁴² (see charts below).

²³⁷ Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013.

²³⁸ Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2006). "Drug Situation in Georgia – 2005." Tbilisi, Georgia: Southern Caucasus Anti-Drug Program.

²³⁹ Ibid.

²⁴⁰ Ibid.

²⁴¹ Ibid.

²⁴² Ibid.

Figure 1. Use of different opioids by patients' treated in 2004 and 2005. ²⁴³

Figure 14: Use of different opioids by patients treated in 2004

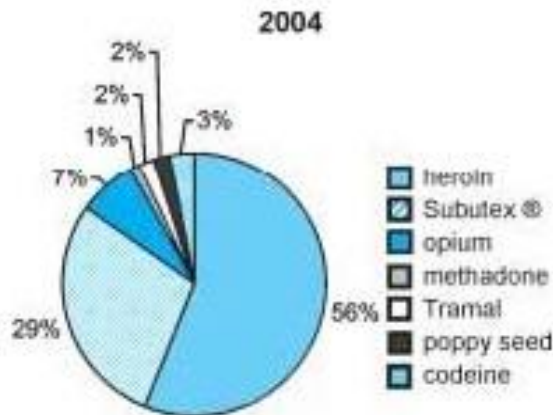
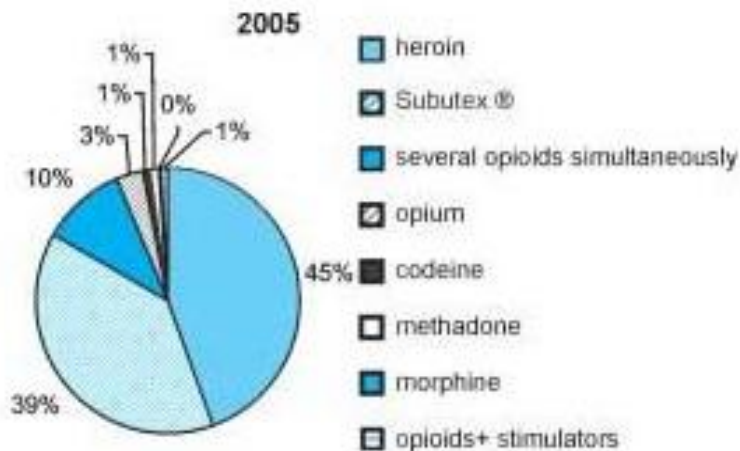


Figure 15: Use of different opioids by patients treated in 2005



In my opinion, the diffusion of Subutex R in Georgia coincides with the period of the emergence of the disco/club culture in the country. With the support of the Western-oriented government, different nightclubs, discos and bars were being opened extensively, a luxury the Georgian society did not have back in the 1990s. I think the disco/club culture created an alternative means for drug dealers to disseminate drugs. While Subutex R was very difficult to obtain, the so called ‘club drugs’ appeared to be very easily available in discos and clubs. A survey conducted in 2005 on teenagers studying in the secondary schools of Tbilisi also confirms the easy availability of hashish and ecstasy.²⁴⁴ Seventy-five of the pupils surveyed declare that it is quite easy for them to obtain hashish and ecstasy. They also

²⁴³The above-mentioned illustration is copied from the report Drug Situation in Georgia 2005, Available at: <http://www.altgeorgia.ge/2012/myfiles/Drug-situation-in-Georgia-2005.pdf>, Accessed: 12.06.14

²⁴⁴Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2006). “Drug Situation in Georgia – 2005”. Tbilisi, Georgia: Southern Caucasus Anti-Drug Program

explain that it is particularly easy to obtain evaporative solutions in general (without specifying which ones), while they name heroin, opium, and Subutex as the drugs that are most difficult to obtain. Interestingly, a number of those surveyed (males) who acknowledged using hashish regularly, also admitted that they also have easy access to other narcotic substances.²⁴⁵

The Annual Report - Drug Situation in Georgia 2005 shows that, with a new government in place, serious changes were also gradually taking place on the black market.²⁴⁶ One of the first changes, which the authors of the afore-mentioned report outline, is the reduction of imports of raw opium and heroin, which, on the one hand decreased the use of these substances, but on the other hand increased the number of Subutex users. Most importantly, instead of alleviating the problem of drug addiction, reduction of the imports of the afore-mentioned substances transformed this problem and Georgian society found itself facing a serious epidemic in the form of the use of home-made drugs. The danger of the diffusion of this epidemic is shown clearly in the afore-mentioned report when the authors talk about the appearance of a new home-made drug called ‘Vint.’²⁴⁷

The Report Drug Situation in Georgia – 2012, clearly shows that the strategy of reducing the supply of drugs in the country in recent years was mainly directed to overcoming the illegal import of narcotic substances. The authors of the report believe that the disappearance of such ‘traditional’ narcotic substances from the black market, such as heroin and Subutex R, changed the drug scene sharply and contributed to the reduction in the use of stimulants and opioids. However, the consumption of home-made drugs prepared from ephedrine or phenylpropanolamine which were available from pharmacies without a prescription, increased.²⁴⁸ In the struggle against drug use and addiction, the new government also set a priority of applying punitive measures (high fines, incarceration, etc.) in addition to creating a deficit of ‘traditional’ narcotic substances on the market, which, in the opinion of many experts and representatives of civil society, was and still remains connected with a lot of violations of human rights. However, some members of the public believe that the strategy based on punishment has resulted in a number of positive outcomes for the country, such as a reduction in drug-related offences.²⁴⁹

²⁴⁵Ibid.

²⁴⁶Ibid.

²⁴⁷Ibid.

²⁴⁸Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). “Drug Situation in Georgia 2012”, Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55> Accessed: 10.07.2013.

²⁴⁹Ibid.

While the afore-mentioned measures may have had a positive effect, I think it is impossible to make such generalized conclusions about the impact of the punitive approach purely on the basis of data on narcotic substances seized from the illegal circulation, and on registered drug-related offences.

Legislative changes and their weaknesses

In the struggle against the use and distribution of drugs, many other countries like Russia, Ukraine and Romania, apart from Georgia, also resort to repressive tactics.²⁵⁰ During the past three decades, the abuse of narcotic substances has sharply increased the cases of criminalization of drug use around the world.²⁵¹ And criminalization has resulted in more frequent application of strict sanctions and imprisonment of drug users. It was surprising and unexpected that a repressive drug policy was not very effective in decreasing the use or diffusion of narcotic substances. Moreover, it resulted in very negative consequences in terms of public health.²⁵² One of the serious weaknesses of criminalization of drug policy is related to the development of home-made substances.

Since 2004, a stimulant called ‘Vint,’ which contains ephedrine and is made in home conditions, has been slowly gaining ground in Georgia, and, at the initial stage, it is popular among the lower social strata due to its relatively low price. According to the authors of the report Drug Situation in Georgia 2005, individuals who use this product, as a rule do not use the services of drug treatment institutions.²⁵³ On the one hand, the authors of the study related this to financial problems, because in 2004 the users of this drug tended to have a low social status and lacked the necessary financial means to receive treatment (information on treatment opportunities and costs on page 66); but another possible explanation offered by the authors of the report had to do with the fact that the epidemic had not yet spread and was only beginning. I do regard this explanation as a prophesy, since Drug Situation in Georgia – 2012 already shows clearly that the use of home-made stimulants, sleeping pills, and other easily available psychotropic substances that can be bought in drugstores without a doctor’s

²⁵⁰Ataiants,J., Merkinaite,S., Ocheret, D.(2012). Policing people who inject drugs: Evidence from Eurasia. Available at: http://www.harm-reduction.org/sites/default/files/pdf/IDPC-briefing-paper_Policing-people-who-inject-drugs-evidence-from-Eurasia.pdf, Accessed: 15.10.2013.

²⁵¹Stevenson,B. (2011). "Drug Policy, Criminal Justice and Mass Imprisonment," Global Commission on Drug Policies, Working Paper Prepared for the First Meeting of the Commission Geneva. Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf, Accessed: 24.04.2013.

²⁵²Ibid.

²⁵³Gamkrelidze, A., Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2005).“Drug Situation in Georgia – 2005“. Tbilisi, Georgia: Southern Caucasus Anti-Drug Program.

prescription, is becoming increasingly popular in Georgia.²⁵⁴ The afore-mentioned report indicates that, according to the beneficiaries of the needle exchange/distribution programs, the price of 1 gram of heroin, as well as one 8-gram tablet of Subutex, amounts to GEL 570, while both the home-made stimulants, such as ‘Vint’ and ‘Jeff’ cost GEL 10-20 (6-12 USD) and the newly introduced Desomorphine - ‘Crokodil’ costs GEL 20 (12 USD); all much cheaper. The availability of such substances, their low price, and the scarcity of the ‘traditional’ narcotic substances has led Georgian society to the problem of ‘toxicomania.’²⁵⁵

Sharpening of the drug use legislation in Georgia

The struggle against drug use and addiction as a grave crime became especially strict from 2006 in Georgia, which was manifested in the announcement of a zero tolerance policy against individuals with drug addiction on the President’s initiative and in the making the Code of Administrative Offences stricter.²⁵⁶ A zero tolerance policy is a policy of punishing any infraction of a rule. With zero-tolerance policy persons in authority are forced not to take into account the severity of the offences or change punishments according to the circumstances; the authorities are compelled to impose a pre-determined punishment regardless of the degree of culpability or mitigating circumstances.²⁵⁷

As noted in the Legal Analysis of Georgian Drug Policy, from July 25, 2006, the previous fine of GEL 75-150 (30-90 USD) stipulated in Article 45, increased to GEL 500 (280 USD) for acquisition and storage of narcotic substances in small amounts without the aim of selling them, and the use of drugs without a doctor’s prescription. Additionally, if the court deems that this sanction is not enough, it has the right to sentence a drug user to up to 30 days imprisonment.²⁵⁸ On July 3, 2007, a law adopted by Parliament changed the category of the crimes envisaged in Part 1 of Article 160 from grave to particularly grave,²⁵⁹ which provides for 11 years of imprisonment for illegal preparation, production,

²⁵⁴Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). “Drug Situation in Georgia – 2012,” Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

²⁵⁵ The term – “toxicomania” was introduced by Georgian drug rehabilitation experts in order to refer to the addiction to home-made drugs.

²⁵⁶Jorbenadze, L. (2012). “Legal Analysis of Georgian Drug Policy.” Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed 18.03. 2013.

²⁵⁷ See detailed information about zero-tolerance at: http://en.wikipedia.org/wiki/Zero_tolerance

²⁵⁸ Ibid.

²⁵⁹ Under the Criminal Code of Georgia there are three categories of crimes according to their gravity: less grave crimes punishable by imprisonment for up to five years, grave crimes punishable by imprisonment for five to ten years, and particularly grave crimes punishable by imprisonment for more than ten years. It is important which category of crime a person has committed in terms of removal of conviction record, pardon, early release, and conditions in a penitentiary

purchase, storage, transportation, shipment, or sale of a narcotic substance.²⁶⁰ As described in the aforementioned Georgian Drug Policy Analysis, the sanction envisaged by Part 2 of this Article was also made stricter, and it now provides for seven to 14 years of imprisonment if the afore-mentioned act is perpetrated: in large quantities, by prior agreement by a group of persons, using official capacity, more than once, by a person who has committed the crime specified in the Chapter of Drug-Related Offences of the Criminal Code.²⁶¹

The author of the Legal Analysis of Georgian Drug Policy outlines the importance of acknowledging that the Criminal Code of Georgia did not and still does not differentiate between a drug user and a drug seller, the so-called dealer.²⁶² The author considers this as one of the grossest weaknesses against the background of the enacted changes, since an act of any drug user can be qualified under both Part 1 and Part 2 of Article 260, which indicates to an unfair attitude on the part of the legislator and makes it possible to impose punishment in a disproportionate manner.²⁶³ The Criminal Code of Georgia also fails to make a distinction between a person ill with drug addiction, a recreational drug user, and a drug dealer in terms of imposing sanctions.²⁶⁴

According to the European Monitoring Center for Drugs and Drug Addiction, the punishment for a small amount of drugs is imprisonment up to 11 years under Criminal Code of Georgia (Article 260); 7–14 years for large amounts; and 8–20 years or life imprisonment for exceptionally large amounts of drugs. There is no clear definition of what is considered a small amount with respect to most of the common substances in Georgia, therefore, any illegally held amount is deemed a large enough amount to attract harsh punishment.²⁶⁵

Such an attitude from the legislator, and the additional strict changes, have led to grave consequences, and to present, numerous individuals with drug-dependence continue to be sentenced to ten years of

institution, since persons who have committed particularly grave crimes face more impediments in making use of privileges envisaged by law.

²⁶⁰Jorbenadze, L. (2012). “Legal Analysis of Georgian Drug Policy.” Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013

²⁶¹Ibid.

²⁶²Ibid.

²⁶³Ibid.

²⁶⁴Ibid.

²⁶⁵European Monitoring Center for Drugs and Drug Addiction. Available at: <http://www.emcdda.europa.eu/publications/country-overviews/ge#gps>, Accessed: 10.07.2013.

imprisonment due to disproportionate punishment.²⁶⁶ The Legal Analysis of Georgian Drug Policy explains that, in theory, neither the law nor the practice of the bodies conducting the proceedings²⁶⁷ provides for a real distinction between Article 273 (illegal preparation, purchase, and storage of a small amount of a narcotic substance for personal use) and Part 1 of Article 260 (illegal preparation, production, purchase, storage, transportation, shipment, or sale of a narcotic substance).²⁶⁸ In practice, acts of both a drug user and a drug-dependent person, detained for the purchase/storage of a certain amount of drugs for personal use, are qualified under Part 1 of Article 260. In addition, as described in the Drug Policy Analysis, there is an inconsistency between Article 45 of the Code of Administrative Offences and Article 273 of the Criminal Code; specifically, Article 273 provides for criminal responsibility for the preparation of drugs for personal use, perpetrated after the imposition of an administrative penalty for such practice, but Article 45 of the Code of Administrative Offences does not envisage administrative responsibility for the preparation of drugs.²⁶⁹ The same law adopted by Parliament on July 3, 2007, also made Article 273²⁷⁰ of the Criminal Code stricter by adding a provision that envisages imposition of criminal responsibility on persons who have been convicted of the same offence before, which means imposing a criminal penalty on drug users again if they repeatedly commit the offence within several years. In addition, the law added a remark to Article 273²⁷¹ of the Criminal Code according to which the court is not legally authorized to impose a fine less than GEL 1,000 as a penalty. And a fine may be applied together with other penalties.²⁷²

²⁶⁶Otiashvili, D., Sárosi, P., Somogy G.L. (2008). “Drug Control in Georgia: Drug Testing and the Reduction of Drug Use?” Available at: http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_15.pdf Accessed: 18.04.2013.

²⁶⁷i.e. the Ministry of Internal Affairs, the Prosecutor’s Office, and courts.

²⁶⁸Jorbenadze, L. (2012). “Legal Analysis of Georgian Drug Policy.” Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013

²⁶⁹Ibid.

²⁷⁰The old wording: “Article 273. Illegal preparation, purchase, storage of a small amount of a narcotic drug, its analogy or precursor for personal use or illegal use without a doctor’s prescription, perpetrated after imposition of an administrative penalty for such practice, shall be punishable by a fine or by socially useful labor for a period of one hundred and twenty to one hundred and eighty hours, or by jail time of up to three months, or by imprisonment for a term not in excess of one year.”

²⁷¹The wording after July 3, 2007: “Illegal preparation, purchase, storage of a small amount of a narcotic drug, its analogy or precursor for personal use or use without a doctor’s prescription, perpetrated by a person previously sentenced to an administrative penalty for such practice or by a person previously convicted for this offence, shall be punishable by a fine or by socially useful labor for a period of one hundred and twenty to one hundred and eighty hours, or by imprisonment for a term of up to one year. Remark: A fine envisaged by this Article shall not be less than double the amount determined for this practice by the corresponding article of the Code of Administrative Offences of Georgia.”

²⁷²Jorbenadze, L. (2012). “Legal Analysis of Georgian Drug Policy.” Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013

Against the background of the legislative changes, stricter laws, and numerous disproportionate penalties, the number of users of home-made narcotic substances keeps increasing, but ‘toxicomania’ is not the only problem that is being exacerbated due to the repressive drug policy.

International experience has shown that a repressive drug policy that is based on the criminal justice system is ineffective in terms of resolving problems of drug use and drug-related offences.²⁷³

For example, a study of recidivism in 15 states of the US found that a quarter of the individuals released from a penitentiary institution returned to prison within three years for violations such as drug use.²⁷⁴ Therefore, it follows that the penitentiary system is not very effective in preventing drug use, because it typically decreases drug use while the user remains incarcerated. Scholars explain the ineffectiveness of the penitentiary system in fighting drug addiction by the fact that, on release from a penitentiary institution, addicted persons experience a lot of difficulties and temptations. These difficulties and temptations are caused by stressors that increase the risk of repeated drug use.²⁷⁵ These include the stigma associated with the status of an ex-offender, the need for housing and legitimate employment, stresses related to re-unifying with family, and a number of requirements for criminal justice supervision.²⁷⁶ Returning to neighborhoods where the individuals with addiction problems used drugs places them in an environment rich in drug cues, which can cause an intense desire to use drugs, the so-called ‘craving.’²⁷⁷ Scholars also argue that the intensive desire to use drugs increases progressively when addicted individuals are re-exposed to the so-called drug cues after drug withdrawal.²⁷⁸ This could explain why many drug-dependent individuals return to drug use after release from prison and highlights the need for ongoing treatment after release.

In recent years, considerable progress has been reported in the sense that governments of many countries have managed drug use and drug dependence as a public health problem which requires

²⁷³Chandler,R.K., Fletcher, B.W., Volkow, N.D.(2009). "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," *The Journal of the American Medical Association*, 301(2),pp.183-190.

²⁷⁴Langan P., Levin D. (2002). "Recidivism of Prisoners Released in 1994." Washington, DC: Office of Justice Programs, Bureau of Justice Statistics; Dept of Justice publication NCJ 193427.

²⁷⁵Shivy, V.A., Wu, J.J., Moon, A. E., Mann, S.C., Holland, J.G., Eacho, C. (2007). "Ex-offenders Reentering the Workforce," *Journal of Counseling Psychology*, 54(4), pp. 466–473.

²⁷⁶Ibid.

²⁷⁷Volkow, N.D., Wang, G.J., Telang, F., [Fowler](#), J.S., Logan, J., Childress, A.R., Jayne, M., Ma, Y., Wong, Ch. (2006). "Cocaine Cues and Dopamine in Dorsal Striatum: Mechanism of Craving in Cocaine Addiction," *Journal of Neuroscience*, 26(24). pp. 6583–6588.

²⁷⁸Grimm, J.W., Hope B.T., Wise, R.A., Shaham, Y. (2001). "Neuroadaptation: Incubation of Cocaine Craving after Withdrawal," *Nature*, 412(6843), pp. 141–142.

treatment, counseling, and medical intervention rather than incarceration.²⁷⁹ Many studies show that drug treatment and counseling programs (the needle exchange program, compulsory treatment, educational and preventive activities, counseling, replacement therapy using drug substitutes like Methadone or Naloxone) are far more effective and productive than the criminal justice system, and that spending on drug treatment is far more efficient than the incarceration of drug-addicted persons, as treatment reduces substance abuse and recidivism.²⁸⁰

Of course, it should not skip our attention that the stricter laws have indeed achieved the goal set by the Georgian state – they practically destroyed reverence to criminal mentality and weakened society’s positive attitude to drug addiction and the young generation’s desire to achieve the image of a successful ‘good guy’ by consuming drugs. However, reforms seldom run smoothly, and, together with many positive results, we have seen the emergence of problems that the makers of the new drug policy did not expect.

Together with the increase of ‘toxicomania’ and the deterioration of health problems, criminalization of drug addiction has entirely done away with the idea that drug addiction is a disease – a chronic disease²⁸¹ – and an individual who uses drugs is an individual who needs professional treatment. Criminalization of drug use has created a lot of obstacles for the group of individuals with drug dependence who are motivated to make use of treatment programs, receive assistance, and get rid of drug addiction. Studies show that when healthcare programs are easily available, the overuse of drugs and mortality caused by drug addiction sharply decreases.²⁸² Improvement and development of medical programs reduces drug addiction and drug use very effectively, but it becomes difficult to make use of treatment services under a repressive drug policy when individuals fear imprisonment and they may refuse to make use of treatment services because of this fear.²⁸³

²⁷⁹Chandler,R.K., Fletcher, B.W., Volkow, N.D.(2009). "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," *The Journal of the American Medical Association*,301(2), pp.183-190

²⁸⁰ Stevenson, B. (2011). "Drug Policy, Criminal Justice and Mass Imprisonment," Global Commission on Drug policies, working paper prepared for the first meeting of the commission Geneva. Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf, Accessed: 24.04.2013.

²⁸¹The National Institute on Drug Abuse (2011). "The Science of Drug Abuse and Addiction." Available at: <http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction>, Accessed: 2.02.2013.

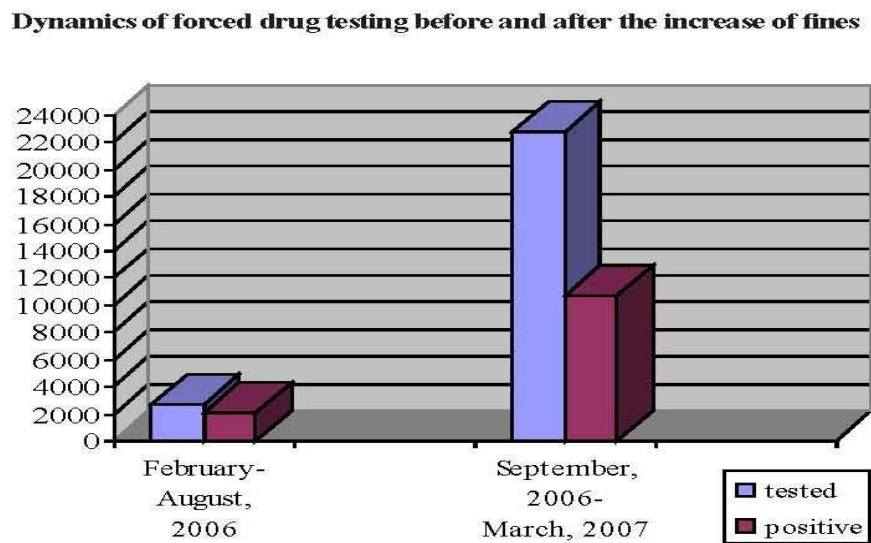
²⁸² Stevenson, B. (2011). "Drug Policy, Criminal Justice and Mass Imprisonment," Global Commission on Drug policies, working paper prepared for the first meeting of the commission Geneva. Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf, Accessed: 24.04.2013.

²⁸³ Roberts, M., Bewley-Taylor, D., Trace, M. (2005). "Facing the Future: The Challenge for National and International Drug Policy." The Beckley Foundation Drug Policy Program Report 6. Available at: http://www.beckleyfoundation.org/pdf/Report_06.pdf, Accessed: 25.04.2013.

The fear was not baseless. Since 2006, any individual for whom the police ‘reasonably suspected’ to be under the influence of illegal substances, could be subjected to ‘street drug testing.’ The reason behind the introduction of the term ‘reasonable suspicion’ was to find legal grounds for ‘street drug testing.’ The term was introduced by the joint order N1049-233n issued by the Ministers of Internal Affairs and Health of Georgia in 2006. Although ‘street drug testing’ is not defined in the document, this practice has become very common.²⁸⁴

Otiashvili et.al.(2008) report that more than 57,000 people were forcefully subjected to testing in 2007 and only 38 percent of them tested positive for drugs, compared to 78 percent in 2006 (MIA, 2008). These data show that more than 35,000 innocent citizens were detained and taken to a testing facility where they were humiliated, falsely accused, and made to wait in long lines for tests²⁸⁵ (See the chart below).

Figure 2. Dynamic of forced drug testing²⁸⁶



In 2008, 50,000 people were forcefully tested for drugs and more than 19,000 of them tested positive; 1,605 persons were imprisoned on the evidence of urine strip tests (whose results are not considered to

²⁸⁴European Monitoring Center for Drugs and Drug Addiction. Available at: <http://www.emcdda.europa.eu/publications/country-overviews/ge#gps> Accessed: 10.07.2013.

²⁸⁵Otiashvili, D., Sárosi, P., Somogy G.L. (2008). “Drug Control in Georgia: Drug Testing and the Reduction of Drug Use?” Available at: http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_15.pdf, Accessed: 18.04.2013.

²⁸⁶ The illustration was copied from the report by Otiashvili, D., Sárosi, P., Somogy G.L. (2008). “Drug Control in Georgia: Drug Testing and the Reduction of Drug Use?” Available at: http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_15.pdf, Accessed: 18.04.2013.

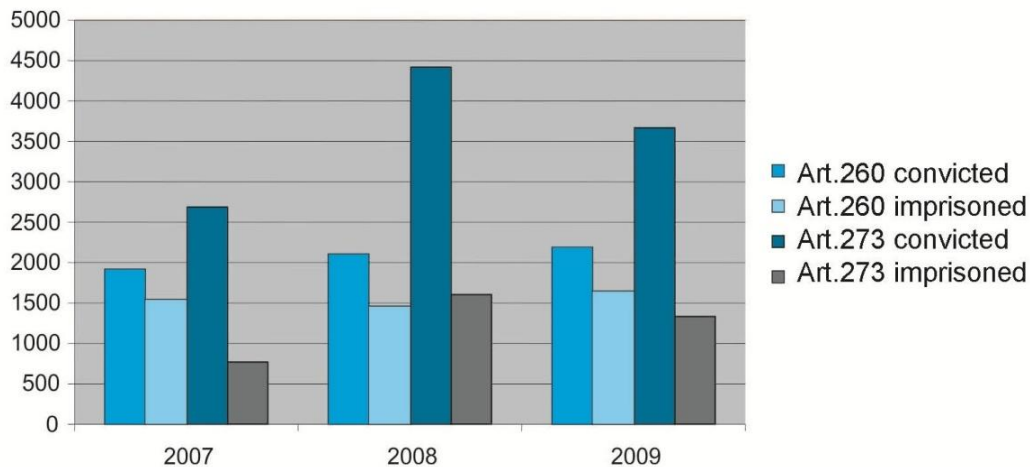
be very accurate). 27,138 people were tested for drugs and metabolites in 2011 by rapid (strip) tests and 8,138 tested positive. By international standards, the results of such tests must be verified in a laboratory in order to be accepted as evidence in court. But the laboratory testing never takes place in Georgia and the court uses these test results as evidence. A great number of people paid massive fines or are imprisoned based on urine strip test results alone.²⁸⁷

Table 9. Results of urine strip tests in 2008 and 2011

2008	2011
from 50,000 people → 38 tested positive	from 27,138 people → 29 tested positive

According to the Report Drug Situation in Georgia 2010, 6,051 persons were convicted of drug-related crimes in 2009, including 3,663 (60.5 percent) for the mere consumption of controlled substances. Additionally, 7,106 persons had to pay drug-related administrative charges in the same year.²⁸⁸

Figure 3. Dynamics of convictions and imprisonment²⁸⁹



²⁸⁷Merkinaitė, S. (2012). A War against People who Use Drugs: The Costs, Available at: http://www.harm-reduction.org/sites/default/files/pdf/costs_report_2012_06_19_1_0.pdf Accessed: 10.06.2014.

²⁸⁸Javakhishvili, J., Sturua, L., Otiashvili, D., Kirtadze, I., Zabransky, T. (2010). Drug Situation in Georgia – 2010. Tbilisi, Georgia: Southern Caucasus Anti-Drug Program. Available at:

http://www.ncdc.ge/uploads/publications/Drug_Situation_in_Georgia_2010.pdf Accessed: 25.04.2013.

²⁸⁹The illustration was copied from the report by Javakhishvili, J., Sturua, L., Otiashvili, D., Kirtadze, I., Zabransky, T. (2010). Drug Situation in Georgia – 2010. Tbilisi, Georgia: Southern Caucasus Anti-Drug Program. Available at: http://www.ncdc.ge/uploads/publications/Drug_Situation_in_Georgia_2010.pdf, Accessed: 25.04.2013.

Current debates: effective planning of drug policy

There is a lot of evidence that despite the zero tolerance policy, drug use and the volume of the black market still continued to expand. Moreover, this approach created a number of new problems.²⁹⁰ However, it is also a fact that some statistical data speak in favor of a criminalized drug policy. The 2004 World Drug Report of the United Nations Office for Drugs and Crime (UNODC) states that ‘though there has been an epidemic of drug abuse over the last half century, its diffusion into the general population has been contained. The figure of less than three percent of the global population (or five percent of the population aged 15 and above) is certainly evidence of containment, particularly when compared with the annual prevalence rate of 30 percent for tobacco.’²⁹¹

One of the main criticisms against the drug legislation that exists in Georgia is that the entire legislation is oriented to the collection of fines and making arrests rather than resolving the problem and reducing the number of drug users.²⁹² Besides, the existing legislation does not contribute to the provision of drug users with such services as voluntary counseling/testing on HIV/AIDS, needle exchange, and other harm reduction programs.²⁹³

However, the law enforcement bodies of Georgia have their own arguments regarding the productivity and effectiveness of the existing criminalized policy. As the Annual Report - Drug Situation in Georgia 2012 states, in 2012, the Prosecutor’s Office and the Analytical Department of the Ministry of Internal Affairs of Georgia conducted statistical studies to assess the drug situation in the country.²⁹⁴ The reports of both of these studies concluded that, thanks to the punitive measures like mass drug tests in the streets, arrest of users, etc. taken by the law enforcement bodies, the drug situation in the country has improved.

The Prosecutor’s Office and the Analytical Department of the Ministry of Internal Affairs of Georgia regarded the decrease in the number of cases of revealed drug-related offences, mainly drug use (which, in its turn, was deemed as an indicator of general reduction in the prevalence of drug use in the country), as one of the important indicators of improvement. As Javakhishvili et al (2012) explain, in

²⁹⁰Kana‘iaupuni, S.M., Gans, M. (2005). “How Effective is Zero Tolerance?” Brief Review. Available at: http://www.ksbe.edu/spi/PDFS/Reports/Educational_Policy/04_05_23.pdf, Accessed: 26.04.2013.

²⁹¹The United Nations Office for Drugs and Crime (2004). “World Drug Report.” Available at: http://www.unodc.org/pdf/WDR_2004/volume_1.pdf, Accessed: 25.04.2013.

²⁹²Georgian Harm Reduction Network (2008). “Shadow Report on the Drug Situation in Georgia for the Years 2006-2007,” pp. 3-15.

²⁹³Ibid.

²⁹⁴Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). “Drug Situation in Georgia – 2012,” Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

order to substantiate such an interpretation, representatives of law enforcement bodies relied on the dynamics of statistics of registered drug-related offences from 2007 to 2011: 8,493 cases in 2007, 8,699 cases in 2008, 6,921 cases in 2009, 5,854 cases in 2010, and, finally, 3,984 cases in 2011 (the Ministry of Justice of Georgia, 2012).²⁹⁵

Table 10. Number of drug-related offences from 2007 to 2011

	2007	2008	2009	2010	2011
Number of cases	8,493	8,699	6,921	5,854	3,984

However, Javakhishvili et al (2012) have questioned this conclusion, stressing that the statistics provided only by law enforcement bodies cannot – and should not – be regarded as an indicator of the decrease in the prevalence of drug use as the reduction of registered drug-related offences may have been caused by other factors, such as:

- 1) a decrease in the intensity of detention of drug users due to a change in the strategies of the law enforcement bodies;
- 2) the users switching to new home-made substances that can be made with precursors easily available in ordinary grocery stores, as a result of which the police was no longer able to detain them with the same intensity as before;
- 3) a difficulty in revealing cases of drug use through routine urine analysis, again, due to the switch to new substances.

But the most interesting argument turned out to be the comparison of the new statistics starting from 2007, which were emphasized in the studies, with the statistical data of earlier years, for example, 2006. In 2006, the number of persons registered because of drug-related offences (mainly drug use) amounted to 3,542²⁹⁶ (Javakhishvili, Sturua, 2009), which was lower than the analogous data of 2011.

²⁹⁵Ibid.

²⁹⁶Javakhishvili, D.J., Sturua, L. (Eds.) et al. (2009). “Drug Situation in Georgia – 2009.” Tbilisi: Southern Caucasus Anti-Drug Program.

At the same time, law enforcers had assessed the drug situation in 2006 as worse than in the following years.²⁹⁷

Therefore, Javakhishvili et al (2012) outline the fact that, although the statistics of the law enforcement bodies are very important, they still cannot provide us with enough evidence to make conclusions on the improvement/deterioration of the drug situation and, accordingly, to plan the right drug strategy.²⁹⁸

The case given above makes it clear how important it is for a country to have a drug strategy that will be based on coherent and balanced (between the strategies of supply and demand), evidence-based (not based on assumptions), explicit, objective, and unbiased monitoring, which, unfortunately, Georgia does not have at this stage.²⁹⁹

Additionally, we should take into account that the resolution of drug-related problems is not connected only with drug policy, and, together with pursuing the right drug policy, it is necessary to pay attention to such issues as the improvement of treatment of drug dependence, perfection of the existing services, development/adaptation of new services, and providing prevention and educational activities.

Stigma at the legislative level

During the repressive anti-drug campaign from 2006 to 2014 Georgian society developed a fear towards people who became known as drug addicts. Of course, it is a noteworthy achievement that drug use is no longer considered as model behavior, though I think that transition from one social model – a positive model of a drug user (‘good guy’) – to another, radically different model – a drug user as a criminal offender – was made as a result of many repressive acts that infringed on human rights. Georgian society still lacks an appropriate definition of an individual with drug use problems. The important fact that drug addiction is a chronic disease which is determined by bio-psycho-social factors³⁰⁰ is still missing in the legislation, in the messages on drug addiction disseminated by the state, and in the public consciousness.

The structural changes in the drug policy have created a stigma at the legislative level which spread quickly throughout society (see detailed information on stigma in Chapter 1, 4 and 5), and people came

²⁹⁷ Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). “Drug Situation in Georgia – 2012”, Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55> Accessed: 10.07.2013.

²⁹⁸ Ibid.

²⁹⁹ Ibid.

³⁰⁰ The National Institute on Drug Abuse (2011). “The Science of Drug Abuse and Addiction”. Available at: <http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction> Accessed: 2.02.2013.

to regard a one-time ‘good guy’ as a criminal offender, which, I think, has not only failed to improve the situation, but also aggravated it.

The majority of the respondents who took part in this study argue that society views drug dependence as a crime, not as an illness, failing to differentiate between users and dealers (see Chapter 5). Having the status of a drug user is equivalent to perpetual rejection and disgrace, which is the result of serious work carried out at the governmental and legislative levels to make this label equal to the status of criminal offender.

The increase of stigma and discrimination against individuals with drug use problems may have been further aggravated by the entry into force of the July 3, 2007 Law on Struggle against Drug-Related Offences, which provides for the deprivation of important civil rights (such as the right to drive a motor vehicle, to practice medicine or law, to work at a teacher-training and educational institution, to work in treasury-funded (budget-funded) bodies of state government and local self-government, passive electoral rights, and the right to make, acquire, keep, and carry weapons) for the duration of three years for the act envisaged in Article 273 of the Criminal Code, i.e. the use of a narcotic substance.³⁰¹ As Jorbenadze (2012) explains, under this law persons convicted under Article 260 are deprived of the right to drive a motor vehicle for five years and the right to practice medicine for ten years.³⁰² For persons found guilty of selling drugs, the maximum period of deprivation of rights is 15 years; in addition, they are deprived of unlawfully obtained and unsubstantiated property. The main weakness of the law, according to Jorbenadze (2012), is that it does not envisage any exceptions in terms of early restoration of rights or reduction of the duration of penalties.³⁰³

However, the reports and studies covering the drug related situation in Georgia also underline other important factors in addition which aggravate the situation related to drug use.

Opportunities and weaknesses of drug treatment in Georgia³⁰⁴

The Annual Report - Drug Situation in Georgia – 2012 says that there are no common agreed criteria for the assessment of treatment effectiveness and treatment protocols and guidelines in Georgia. Their

³⁰¹Jorbenadze, L. (2012).“Legal Analysis of Georgian Drug Policy.” Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed 18.03.2013.

³⁰²Ibid.

³⁰³Ibid.

³⁰⁴Information about the treatment and rehabilitation services in Georgia is taken from the following reports and sources:“Drug Situation in Georgia – 2012,” “Legal Analysis of Georgian Drug Policy – 2012,” the website of the European Monitoring Center for Drugs and Drug Addiction.

development and introduction is a task for the near future.³⁰⁵ However, based on the information from different reports and websites, I will try to form a general picture of treatment services related to drug addiction in Georgia.

After the disintegration of the Soviet Union in 1991, two drug treatment clinics – one public (the in-patient facility of the Institute on Addiction) and the other private (the Bemoni clinic³⁰⁶) – opened in Georgia. The capacity of both clinics was extremely limited, and both of them offered patients pharmacological treatment and short-term psychotherapy. However, the opportunities for treatment have increased relatively since then and the country now has four in-patient clinics for people with severe drug dependence. Yet, according to the authors of Drug Situation in Georgia 2012, the treatment is still under the inertia of the biomedical model of the Soviet Drug Treatment approaches and puts less emphasis on the psychological, behavioral, social and spiritual dimensions of the patient (and, accordingly, of the disease). Usually, the treatment is limited to a two-week detoxification course followed by one to six months of out-patient treatment after the patient has been discharged. Generally, the bulk of the patients of drug treatment clinics were opioid users, most of them heroin addicts. In 2008, the number of home-made methamphetamine and mezhcathinone users who completed detoxification treatment increased. In 2009, 584 patients successfully completed detoxification treatment (841 in 2008, and 1092 in 2007). Most of the patients were men aged 25-39 (402 out of 584 patients in 2009). Only 12 women received medical treatment for drugs in 2009.³⁰⁷

Table 11. Number of detoxified patients from 2007 to 2009

Year	2007	2008	2009
No. of patients	1092	841	584

³⁰⁵Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). “Drug Situation in Georgia – 2012,” Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

³⁰⁶Clinic Bemoni has 20-years experience (since 1994) in treating drug and alcohol dependent individuals. The clinic developed an effective, comprehensive program for treatment and rehabilitation. Bemoni has two-bed comfortable wards and rooms for meetings and working in groups. The treatment in the clinic is anonymous. Individual rooms are designated for confidential conversations with psychologists and narcologists. During times between the procedures social workers are always with the patients. See details at: <http://www.med.ge/index.php/clinic/narcology/268-bemoni>, Accessed: 16.06.14.

³⁰⁷Javakhishvili, J., Sturua, L., Otiashvili, D., Kirtadze, I., Zabransky, T. (2010). Drug Situation in Georgia – 2010. Tbilisi, Georgia: Southern Caucasus Anti-Drug Program. Available at: http://www.ncdc.ge/uploads/publications/Drug_Situation_in_Georgia_2010.pdf, Accessed: 25.04.2013.

The majority of patients leave out-patient treatment in the very first month, because on the one hand, they think that one simple detoxification course is enough to improve their condition, and, on the other hand, they find it difficult to pay for the treatment. Abstinence-oriented treatment is mostly paid for by patients. The cost of treatment is very high: the cost of a 9-day detoxification course, together with a two-week initial rehabilitation, varies from GEL 1,250 to GEL 2,250 (720 USD -1290 USD). In 2009, the Ministry of Health resumed funding for a small-scale state program of drug dependence treatment.³⁰⁸ In 2011, in the four drug treatment in-patient facilities functioning in the country, 80 out of 270 cases of drug dependence treatment were funded by the state program.³⁰⁹

According to the Annual Report - Drug Situation in Georgia 2012, the abstinence-oriented treatment, which is very expensive and, at the same time, is not oriented to psychological rehabilitation, is less effective; it does not exert much influence on the condition of drug-dependent persons and the rate of recidivism is very high.

Another option for drug dependence treatment is to be involved in an opioid substitution therapy program which was launched in Tbilisi in 2005, initially as a pilot program for opioid drug addiction. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) issued a grant to fund that program; but the grant funded only addiction treatment. The Georgian government saw that this treatment method was important and had positive results and decided to co-finance the opioid substitution treatment in 2008. In the government funded programs the state pays for the methadone and patients only pay service fees; the monthly payment for treatment is GEL 150 (USD 65). Because of the state co-financing, more people are engaged in the treatment. By January 2010 the country had 14 programs in eight regions (and one OST was created in maximum security prison No. 8, where 1200 patients are being treated). In 2010, 800 persons were treated in state co-financed programs and 400 were treated in GFATM-funded programs.³¹⁰

The methodology of substitution therapy was determined by a normative act. The aims and objectives of the treatment were determined as follows: 1) improvement of somatic and psychic condition, social adaptation, and social reintegration of persons ill with opioid addiction; prevention of HIV infection, hepatitis C, and other diseases that are transmitted by injection; 2) achievement of the condition of

³⁰⁸ Prior to 2006, in-patient treatment of drug-dependent persons was funded from the state budget with a limited amount.

³⁰⁹Javakhishvili, D.,Balanchivadze, N.,Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski,T.(2012). "Drug Situation in Georgia – 2012," Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

³¹⁰Javakhishvili, J., Sturua, L., Otiashvili, D., Kirtadze, I., Zabransky, T. (2010). "Drug Situation in Georgia – 2010." Tbilisi, Georgia: Southern Caucasus Anti-Drug Program. Available at: http://www.ncdc.ge/uploads/publications/Drug_Situation_in_Georgia_2010.pdf, Accessed: 25.04.2013.

long-term remission in patients through replacement therapy and medical-social rehabilitation; 3) quitting of injective drug use by HIV-infected opioid-dependent persons and improvement of their psycho-somatic condition; 4) drawing injective drug users to medical institutions with the aim of assessing their hygienic education and checking their health condition (for HIV infection/AIDS, syphilis, etc.); 5) re-socialization of persons involved in the replacement therapy program.³¹¹

Although the substitution therapy program was launched and its scale increased in the subsequent years, Javakhishvili et al (2012) argue that this program has some weaknesses and alone it cannot cover a considerable number of drug users. The causes of this problem include a continuing lack of trained human resources in this field and a lack of institutions to provide proper, relevant training.³¹²

Figure 4. Patients treated by the narcological system in Georgia, 2003-2009 ³¹³

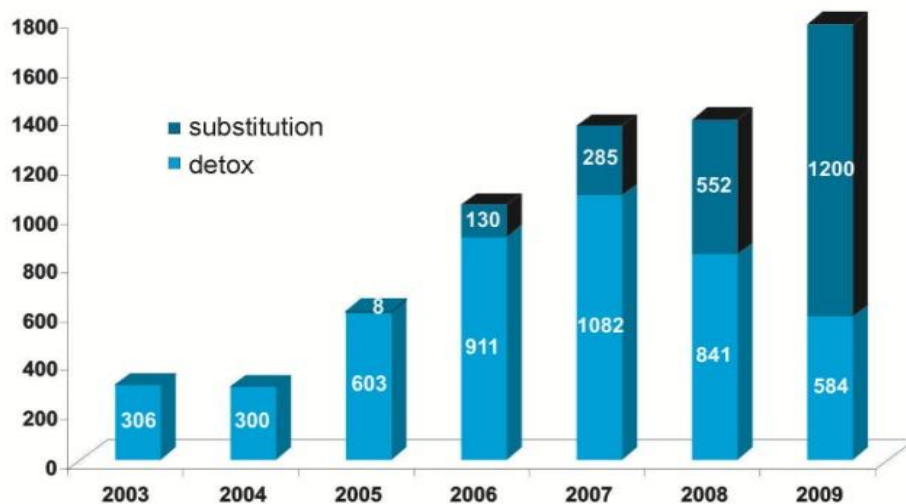


Figure 2: Patients treated by the narcological system in Georgia, 2003-2009 (Todadze K., 2009, Sturua L. 2010)

Regarding the psychotherapeutic services, the authors of Drug Situation in Georgia – 2012 believe that the psychotherapeutic approach in drug dependence treatment is not sufficiently developed in the country: there is a lack of adequately trained staff and there are no institutional mechanisms to ensure

³¹¹Javakhishvili, D.,Balanchivadze, N.,Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski,T.(2012).“Drug Situation in Georgia – 2012,” Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

³¹²Ibid.

³¹³ The illustration was copied from the Report Drug Situation in Georgia 2012, Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.06.2014.

the training of specialists. The approaches used are not based on scientific evidence and nor are the guidelines provided by the UN.³¹⁴ Nor are the mechanisms of professional licensing in place.³¹⁵

A relatively well-developed model of treatment in Georgia, according to the Annual Report Drug Situation in Georgia –2012, is the harm reduction approach. And the authors of the afore-mentioned report explain this fact by the donors' (the Global Fund, different organizations of the UN, the EU and its member countries, Open Society Institute, etc.) particular focus on harm reduction, due to the danger of HIV/AIDS, which is spreading rapidly throughout the post-Soviet space.

According to Javakhishvili et al. (2010), in 2010, Georgia had 2,497 officially registered HIV cases, where men made up 75 percent (1,849) and women 25 percent (648) of the patients. The age of the majority of patients (60 percent) ranged from 29 to 40 years. Of those patients, 1,369 lived to develop AIDS, and 583 of them died. Most of the registered persons (58.4 percent) reported having contracted HIV by injecting drugs. In other cases the causes of HIV were heterosexual transmission (35 percent), mother to child (2.3 percent), homosexual transmission (2.7 percent), undetermined (1.0 percent), and blood transmission (0.6 percent). The AIDS Center data (2010) shows that two thirds of the patients who contracted HIV had heterosexual contact with injecting drug users. The rate of HIV infection among injecting drug users range from 1.5 percent to 4.5 percent, depending on the locality.³¹⁶

As of 2006, only seven NGOs, which established the Georgian Harm Reduction Network (GHRN), were active in the area of harm reduction. At present, the network unites more than 20 organizations and is recognized as one of the most important entities in this field. Nevertheless, the sustainability of harm reduction in the country is brought into question, as almost all services that exist today are funded by the international sector (mainly the Global Fund), while the state does not yet allocate budgetary funds in this direction. In Georgia, harm reduction activities include the following: distribution of syringes/needles, condoms, and informative materials; voluntary counseling and testing (VCT) for HIV infection, hepatitis C and B, and syphilis; equal education; raising of consciousness of injective drug users about risks related to drug use; and advocacy for legislative changes and policy

³¹⁴ WHO, UNODC & UNAIDS (2008). Principles of Drug Dependence Treatment. Discussion Papers. 1st ed. Vienna, UNODC.

³¹⁵ Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). "Drug Situation in Georgia – 2012," Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

³¹⁶ Javakhishvili, J., Sturua, L., Otiashvili, D., Kirtadze, I., Zabransky, T. (2010). "Drug Situation in Georgia – 2010". Tbilisi, Georgia: Southern Caucasus Anti-Drug Program. Available at: http://www.ncdc.ge/uploads/publications/Drug_Situation_in_Georgia_2010.pdf, Accessed: 25.04.2013.

reform. Member organizations of the GHRN now operate in the ten low-threshold combined centers where beneficiaries can receive sterile injection instruments and the VCT service.

Despite the fact that the direction of harm reduction is more or less developed and unites a number of NGOs under its wing, against the background of the existing repressive drug policy, it is quite difficult to provide individuals with drug use problems with the services offered by the Harm Reduction Network.³¹⁷

If we summarize the existing situation in terms of treatment services, we will get a picture in which the forms of treatment are undiversified and scarce, the quality of treatment is not ensured, and treatment is very expensive because in most cases (for detoxification and psycho-rehabilitation) the patients have to pay alone – all this makes it difficult to take patients' individual needs into account and to ensure their satisfaction with the treatment results. According to a study conducted in 2008, most of the drug treatment institutions aim at achieving abstinence and regard the duration of abstinence as the leading indicator of treatment effectiveness, whereas the leading indicator for the patient is the quality of life, which is ignored by the institutions and specialists providing the service.³¹⁸ As for the harm reduction services, it is not so easy to administer them against the background of the repressive drug policy.

However, it should also be noted that despite the fact that the authors of the reports reviewed in this chapter criticize and analyze the weaknesses of different treatment options and services, when talking about weaknesses and limitations they do not outline the lack of female-oriented services. The authors do not even mention the issue of female-specific treatment options. The information regarding the lack of female-oriented treatment options is presented by Otiashvili et al. (2013) in the article 'Access to treatment for substance-using women in the Republic of Georgia: Socio-cultural and structural barriers.' Based on the in-depth interviews with 55 females with drug dependence and 33 health service providers, Otiashvili et al. (2013) show that the vast majority of substance use treatment and low-threshold programs lack the knowledge and skills to address the unique needs of women, and are male-oriented.³¹⁹ Moreover, the authors even argue that the treatment providers did not understand the needs

³¹⁷Georgian Harm Reduction Network (2008). "Shadow Report on the Drug Situation for the Years 2006-2007," pp.3-15.

³¹⁸Todadze, Kh., Kavtashvili, E., Khintibidze, Q. (2008). The Assessment of Drug Treatment in Georgia. Tbilisi.

³¹⁹Otiashvili, D., Kirtadze, I., O'Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012) "Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers." International Journal of Drug Policy, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

of women, lacked the comprehensive knowledge of gender-specific characteristics of disease progression, and had only vague ideas about women-specific interventions.³²⁰

Conclusion

On the basis of the overview given above, we get a picture according to which the situation in Georgia for the past 30 years has not been enviable – either in terms of the legislation on drug policy or treatment and rehabilitation of individuals with drug addiction. Following the collapse of the Soviet Union, the country found itself in a very difficult situation and so far has not managed to recover from it and to start moving in the right direction. The country strengthened its already strict and invasive legislation, but this has not helped reduce the number of drug addicts. Treatment methods, on the other hand, have remained the same and are guided by Soviet era methods and reflect the ideology of the time.

At the same time, another, no less serious problem –Georgian society’s incorrect attitude to drug addiction in the past 30 years – has been added to these problems. The historical overview given in this chapter clearly demonstrates that the use, production, and supply of drugs is generally closely connected with a number of economic, social, and cultural issues, which once again proves that drug addiction is not an isolated system; it is a complex problem influenced by many socio-demographic factors.³²¹ Problem use of drugs and, to some extent, drug trade itself are a dimension of wider structural, social, and cultural problems.³²² There is a lot of evidence that severe social, economic and political conditions create fertile grounds for widespread and problem use of drugs.³²³

The situation overview clearly outlines three particularly important factors which should be taken into consideration when analyzing the Georgian situation regarding drug use:

³²⁰Ibid.

³²¹ Roberts, M., Bewley-Taylor, D., Trace, M. (2005). "Facing the Future: The Challenge for National and International Drug Policy." The Beckley Foundation Drug Policy Program Report 6. Available at: http://www.beckleyfoundation.org/pdf/Report_06.pdf, Accessed: 25.04.2013.

³²²Room, R. (2005). "Stigma, Social Inequality and Alcohol and Drug Use," *Drug and Alcohol Review*, 25, pp. 143 – 155.

³²³Shaw, A., Egan, J., Gillespie, M. (2007). "Drugs and Poverty: A Literature Review." A Report Produced by the Scottish Drugs Forum (SDF) on behalf of the Scottish Association of Alcohol and Drug Action Team. Available at: <http://www.dldocs.stir.ac.uk/documents/drugpovertylitrev.pdf>, Accessed: 26.04.2013.

- a) The existing repressive drug policy in Georgia, which does not take into account the difference between drug users and drug sellers, the so-called drug dealers;³²⁴
- b) The decrease of drug imports on the black market. After 2003, imports of drugs on the black market in Georgia gradually decreased. At first, this affected substances such as heroin and poppy straw, and later touched the drugs of other groups as well.³²⁵ And the deficit of the afore-mentioned substances in the country, in its turn, contributed to a change in the type of drug addiction, an increase in the number of users of home-made drugs, and the diffusion of ‘toxicomania.’
- c) The lack of adequate and comprehensive information regarding drug use and addiction problems – it is my opinion that the most difficult and problematic processes, such as the drug addiction boom, ‘toxicomania’, stigma, social rejection of drug users, low motivation to receive treatment, etc. may be consequences of the incorrect information that society has, on the basis of which it responds to the problem of drug addiction.
- d) The limited options of treatment and that the psychotherapeutic approach in drug dependence treatment is not sufficiently developed in the country: there is a lack of adequately trained staff, and there are no institutional mechanisms to ensure the training of specialists.

I am assuming that just as in the corrupt system (in the Georgia of the 1990s), such factors as corrupt law enforcement systems, easy availability of drugs, criminal underworld mentality, and societal prejudices against people who use illegal drugs made it very difficult to receive treatment (because a large part of society considered the drug addiction policy as good form and failed to assess the real severity of the problem). Under the repressive drug policy, it is still difficult to make use of the treatment services, and the situation of individuals with drug addiction in general also remains hard. As society has constantly been given incorrect and distorted information about drug addiction, it is yet to be realized clearly, at the state and public levels, that the struggle against this problem requires treatment and prevention.

In recent years, violation of human rights, stigma, discrimination and wrong/offensive terminology has become common among journalists covering drug addiction problems. Georgian journalists use phrases

³²⁴Jorbenadze, L. (2012). “Legal Analysis of Georgian Drug Policy.” Available at:

<http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013.

³²⁵Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2006). “Drug Situation in Georgia – 2005.” Tbilisi, Georgia: Southern Caucasus Anti-Drug Program. Available at:

<http://www.altgeorgia.ge/2012/myfiles/Drug-situation-in-Georgia-2005.pdf>, Accessed: 18.03.2013.

like: ‘black plague,’ ‘deadly disease,’ ‘incurable disease,’ ‘cruel disease,’ ‘victim of AIDS,’ etc., which enhances the stereotype and contributes to the establishment of stigma and discrimination in society.³²⁶ What’s more, in their speeches, the ex-president Mikheil Saakashvili and the representatives of the Ministry of Internal Affairs used to and still do associate all drug users, irrespective of their type, with the criminal underworld. The speech given by Mikheil Saakashvili in Parliament in February 14, 2006, is another confirmation of this fact. Below is the unedited version of the speech:

President Saakashvili’s annual address to Parliament on 14th of February 2006:

“I am announcing a new draft law with zero tolerance for petty crimes. I will introduce amendments to the Criminal Code which will abolish probation sentences for burglary, mugging, pick-pocketing and possession of drugs. There will be no probation sentences. No judge will be able to release someone on the basis of their own views on humane reasons. Those who commit these crimes will go to prison because they damage our society...

For that we will build a new remand prison in Tbilisi for 3,000 or more prisoners if necessary. We are always prepared to make more room for bandits; to take them off our streets and away from our schools so that we can forget about them. There will be zero tolerance for any kind of petty crime, my friends. That is our new, very firm, policy, which the judiciary, Parliament, the Executive Government and the police should adopt.

The unending fight against drug addiction; Do you know what a tragedy this is? One of the main narcotics trafficking routes from Afghanistan goes through Georgia. The more the income of young people grows, the more the price of drugs falls. It is now easier to find drugs than bread. I am announcing that over the next four months every state employee will undergo a proper drugs test...³²⁷

The President’s address clearly shows a very strong stigma; absolutely all drug users are presented as the enemies of society and are accused of corrupting and damaging it. The President directly calls on society to discriminate and ostracize the said persons. Such appeals led to negative results and caused the deterioration of drug users’ health and the many associated problems described in this chapter. Although expert circles have frequently conducted discussions on the necessity of treatment in recent years,³²⁸ unfortunately these discussions have yet to reach the broad mass of society, and no serious work has been done with the public in the form of an information campaign. Accordingly, a society

³²⁶ See details at: <http://online.tsu.edu.ge/ge/science/9958/?p=9>, Accessed: 17.06.14.

³²⁷ See detailed speech at: <http://www.drugpolicy.dsl.ge/eng/news.htm>, Accessed: 17.06.14.

³²⁸ For additional information, see: <http://www.tavisupleba.mobi/a/24942193/full.html>, Accessed: 19.04.2013.

that is constantly fed with the cliché - drug users are criminals - through the media, develops a negative and hostile attitude to drug-dependent individuals. And this hostile attitude, in its turn, brings negative consequences for the health condition of a number of individuals with drug use problems.

Therefore, it turns out that the three essential factors reviewed in this chapter – Drug legislation, Drug market and Society’s attitudes to drugs and drug addiction - create the circle of a complex system which should be taken into consideration when working on issues of drug addiction in Georgia.

Chapter 4

Opinions of the Georgian Drug Experts

Introduction

This chapter explores gendered claims about drug use in the views of contemporary drug rehabilitation experts in Georgia. When scholars separate the motivations of men and those of women for drug use, gender plays a critical role in structuring plausible empirical accounts of drug use. Yet gender may also operate in a less explicit way in shaping experts’ assessments of drug addiction. Indeed, a number of scholars invoke gender stereotypes, explaining women’s drug dependence in terms of their emotional nature, depression, and other types of psychological problems,³²⁹ while attributing men’s drug dependence to risk-taking behaviors and adolescent male bonding.³³⁰

To investigate how gender operates in the analysis of drug use in Georgia, I designed a study of expert opinions for a country pervaded by patriarchal norms and values. Using interview data from 20 Georgian drug rehabilitation experts (see details about the selection of experts in the Methodology Chapter), I examine gendered accounts of the motivations and causes of drug use, the gender-specific problems they encounter, and the solutions they offer for successful treatment of women who have drug use problems. I sought to determine to what extent Georgia’s patriarchal culture influences experts’ perceptions of and treatment protocols for male and female drug use. Although the experts identify violence, stigma, and lack of female-oriented services as a particular problem for women with

³²⁹Gomberg, E.S.L. (1982). “Historical and political perspective: Women and drug use,” *Journal of Social Issues*, 38 (2), pp. 9-23.

³³⁰Akers, R. L. (1998). “*Social learning and social structure: A general theory of crime and deviance.*” Boston, MA: Northeastern University Press.

drug use problems, they also rely on multiple gender stereotypes in their accounts of women's recourse to drugs, the stereotypes that underestimate the agency of women and may undermine successful intervention strategies.

Reasons for Drug Use

In Georgia, 40,000 injecting drug users are officially registered as systematic users and 4,000 of them are women- which is 10 percent.³³¹ In terms of reliability, these are the only data because there have been no studies to determine the exact number of drug users in Georgia.³³²

The experts interviewed in my study acknowledge that men and women with substance use problems differ in many ways, and the major differences, according to their opinion, are connected to their reasons for drug use, social barriers they encounter, and their treatment needs. When examining the expert interviews, I focus on these three topics and analyze how the explanations provided by my respondents are constructed, and whether gender determined stereotypes and ideologies have their impact on experts' opinions and thoughts. The first topic of discussion in my interview guide was about the reasons and motivations for drug use.

As the experts observed, men usually begin experimenting with drugs in their teenage years, between the ages of 12 and 15, their drug use is often connected with their circle of friends, and the majority of them start by using marijuana, then switch to injective drugs. The experts think that men are more likely to abuse drugs or alcohol in a social setting, together with friends.

'Boys often start to use drugs in their teenage years and their drug behaviour is connected with their social environment. Just imagine that you are young, inexperienced, you have no relevant information about drugs, and you have an enormous interest and desire to do the same as others because it is acceptable in your social circle.'(R3, male, psychiatrist, professional from medical center Uranti, 50-55 years old)

The Georgian experts emphasize that, based on their own observation, the main reason for experimenting with drugs, in the case of men, is interest and their circle of friends. As they explain, the local community and environment can greatly influence the way an adolescent views drug and alcohol

³³¹Sirbiladze, T. (2010). "Estimating the Prevalence of Injection Drug Use in Georgia: Consensus Report." Tbilisi: Bemoni Public Union.

³³²Javakhishvili, D.J., Sturua, L., Otiashvili, D., Kirtadze, I., Zabransky, T. (2011). "Drug Situation in Georgia 2010," Overview, *Adiktologie*, 11(1), pp. 42-51.

use. If the community makes drugs and alcohol easily available to adolescents, is tolerant of relaxed drug and alcohol rules, or drug and alcohol use is popular in the community, then adolescents are more likely to abuse them. If an adolescent believes their community is safe and supportive, they are less likely to use drugs or alcohol.³³³

As for women, the experts say that women experiment with drugs for the first time later than men and in most cases initial drug experimentation is connected with a woman's drug-using partner. All the experts, without exception, name men as the main cause of drug use by women. Some of them even note that *'95 percent of drug-using women, if not more, start using drugs due to the offer and will of men and in submission to them.'* (R6, male, psychiatrist, professional from medical center Uranti, aged 30-35).

'Women more often than men have a sexual partner who uses injective drugs and who is also the primary initiator of using shared needles.' (R16, female, Psychiatrist, professional from the Research Institute on Addiction, 40-50 years old)

'In the beginning everything is OK. A man introduces his partner to drugs, he just offers them to her, they are in love, they have fun and using drugs together is related with more fun and more pleasure. The woman has the feeling of equality, because they are behaving in the same way. She is using forbidden drugs with him together. But when she realizes what is going on, she understands that she is already dependent and all other problems crop up.' (R3, male, psychiatrist, professional from medical center Uranti, 50-55 years old)

While explaining the reason why men offer drugs to their female partners, the Georgian experts referred to situations where the first contact with drugs happens for fun and in order to share the same feelings, pleasure and emotions. However, during further discussions, most of my interviewed experts mentioned that most men show aggression and irritation when women refuse to continue or which to cease their drug use. Also, the literature shows that the male partner generally discourages the female from stopping drug use and often reacts with increased violence and abuse against the woman's desire to stay abstinent.³³⁴ On the question: 'why do men discourage their female partners from stopping drug use?' the experts provided me with very general and less in-depth arguments, ignoring the issue of

³³³Mayberry, M. L., Espelage, D. L., & Koenig, B. (2009). "Multilevel modeling of direct effects and interactions of peers, parents, school, and community influences on adolescent substance use," *Journal of Youth & Adolescence*, 38(8), pp.1038-1049.

³³⁴United Nations Office on Drugs and Crime (2006), "HIV/AIDS Prevention and Care for Female Injecting Drug Users." Available at: http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf, Accessed: 5.12.13.

patriarchal structure and male dominance. The issue that most of them touched upon was that males with drug use problems force their partners to use drugs believing that it will prevent interpersonal problems caused by their own addiction. These problems may be caused by their partner's dissatisfaction with the lack of support, interest, love, understanding, and involvement in family needs and problem-solving.

'In order to avoid the endless dissatisfaction of his female partner, he urges his partner to start living like him and experience the pleasant feelings associated with drugs together with him, as well as to take care of obtaining drugs together.' (R11) *'Male drug addicts exert a very strong influence on their sexual partners. The majority of my female patients were forced to start using drugs by their husbands or boyfriends, and when I asked them why they had obeyed them so foolishly, they answered that their husbands had tempted them and they had been unable to resist the temptation. They said they wanted to be with them and were unwilling to lose the person they loved.'* (R13, female, psychiatrist, professional working in the Research Institute on Addiction, 40-50 years old)

On the one hand, the explanation offered by the experts may be realistic, because it is no surprise that no man who uses drugs would want anyone to make him feel uncomfortable and interfere with his drug use. However, I should mention that while talking and discussing this subject, the Georgian experts ignored the issue of a power imbalance between men and women and did not try to analyse and explain this problem in a more complex and in-depth way.

International scholars who have analyzed women's drug use and violence from the gender and feminism perspective have provided an insight into male power and domination. Regarding the role of a male partner in female drug use, the explanations presented by international scholars mostly rely on the fact that by making their partners dependent on drugs, men reinforce women's dependence, their subordinated position, and their control over them.³³⁵ I think that the feminist point of view is of immense importance while analyzing the men's role in hindering their partner's abstinence. If we review the Report by the United Nations Office on Drugs and Crime (2006), we will find some very important facts demonstrating women's subordination and vulnerability and male partners' domination over them. The Report by United Nations Office on Drugs and Crime (2006) demonstrates that because of the unequal power balance, women have greater difficulties abstaining from drug use, particularly if

³³⁵Martin, S., Kilgallen, B., Dee, D., Dawson, S., & Campbell, J. (1998). "Women in a Prenatal Care/Substance Abuse Treatment Program: Links between Domestic Violence and Mental Health," *Maternal and Child Health Journal*, 2(2), pp.85-94.

their male drug-injecting partner continues and supports injecting.³³⁶ It is said in the report that very often male partners even discourage females from seeking help and involvement in treatment. The second example, which also demonstrates the power imbalance between the couples, is clearly demonstrated in the case of using shared needles. According to the Report, it is a common practice for a female drug injector to use the needle after her partner and it is often impossible for a woman to ask for clean injection equipment from her partner as it implies that she does not trust him. A refusal to use a partner's contaminated injecting equipment also increases the risk of intimate partner violence and such violence is often supported by cultural constructs whereby the male partner is free to exert power and control.³³⁷ Therefore, females are at least more than twice as vulnerable as males to HIV in terms of being infected via a shared needle.³³⁸

The third argument demonstrating females' subordination reported in the afore-mentioned report is related to females' high-risk sexual activities. The report describes that due to the lack of negotiating strength in terms of safer sex (such as consistent condom use) the reason for which is male domination of sexual roles, females with drug use problems mostly engage in high-risk sexual activities in addition to their injecting drug use. The problem related to the stereotyped gender relationships, which is a major barrier for females in terms of maintaining safe-sex practices with their partners, appears to be common for women in general, but as the authors of the report notice, for females who are injecting drug users it is even more severe since they are marginalized by society and thus often have strong feelings of powerlessness, and low levels of self-esteem and self-confidence.³³⁹ The data presented in the afore-mentioned report provide perfect arguments in order to assume that drug dependency in women gives more control and power to men over them.

Despite the fact that the experts did not mention the patriarchal structure, power imbalance and gender role stereotypes, most of them used words like 'submissiveness' and 'obey' in order to answer my questions why do women continue using drugs despite the fact that they may not want to do so.

³³⁶United Nations Office on Drugs and Crime (2006), "HIV/AIDS Prevention and Care for Female Injecting Drug Users." Available at: http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf, Accessed: 5.12.13.

³³⁷ The Global Coalition on Women and Aids (2011) "Women who use Drugs, Harm Reduction and HIV." Available at: <http://www.womenandaids.net/CMSPages/GetFile.aspx?guid=74d74180-8cba-4b95-931e-90bd0c4abef4&disposition=inline>, Accessed: 5.12.13.

³³⁸United Nations Office on Drugs and Crime (2006), "HIV/AIDS Prevention and Care for Female Injecting Drug Users." Available at: http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf, Accessed: 5.12.13.

³³⁹ Ibid.

'A woman obeys her partner, she behaves in the way she is asked to behave. You know that women are submissive and therefore it is difficult for her to say simply 'No' and reject his offer to use drugs.' (R4, female, psychotherapist having her own private practice, 50 < years old)

The answer that women obey their partners was no surprise to me. And actually this answer can also be analysed from the perspective of the male domination paradigm. Research demonstrates that Georgia represents an example of a male dominated country where women are supposed to be in less priority positions.³⁴⁰ Patriarchal norms and values in the country demand women to be obedient and submissive and the data presented in the study - *National Research on Domestic Violence Against Women in Georgia 2010* make good examples of this.³⁴¹ According to this study, 50.7 percent of the women surveyed thought that 'a good wife should obey her husband even if she does not agree with his decision,' and 45 percent believed that 'a man must show his wife/partner clearly who is the head of the family.'³⁴² These percentages show a trend acknowledging the position of authority held by men due to their gender role in society. They are not only entitled, but also required to make decisions. According to this logic, we can assume that if the use of drugs is a decision made by men, if men decide that their partner should continue using drugs, accordingly women are expected to do the same.

Another interesting example offered by the Georgian experts explaining why men who use drugs may force their partners to continue using drugs and why they may forbid and deny women an opportunity to cure their dependence is related with gaining an accomplice. The experts noted that sometimes men need an accomplice to help them obtain drugs and share actions needed to obtain drugs. And their wives or partners may go out of their way to help them instead of interrupting them.

'Everybody needs an accomplice to help in obtaining drugs. Money and help and support is needed. A wife or girlfriend can be a perfect partner when she is also dependent and when she also needs her daily dose...She can help him, she can do everything... It is a fact that female users even undertake sex work very often in order to pay for drugs for themselves and their partners.' (R19, male, professor/narcologist, professional working in the Research Institute on Addiction, 45-55 years old)

³⁴⁰Chitashvili, M., Javakhishvili, N., Arutiunov, L., Tsuladze, L., Chachanidze, S. (2010), "*National Research on Domestic Violence against Women in Georgia.*" Available at: <http://www.genderbasedviolence.ge/conimages/annual-eng.pdf>, Accessed: 5 July 2012.

³⁴¹Ibid.

³⁴²Ibid.

The Report by the United Nations Office on Drugs and Crime (2006) suggests that sex work is a common income-generating activity for some women who are drug users.³⁴³ Moreover, the Report by the Women's Health Victoria (2008) makes it obvious that women who use drugs are more likely to undertake sex work to pay for housing, food and drugs for themselves and their partners.³⁴⁴ Some of the Georgian experts even noted that despite the fact that a woman can be the main drug obtainer, she has no right to use drugs without her partner's permission.

'Very often, men involve women in the process of obtaining drugs, and women obey the rules established by men by all means – they may obtain drugs, but they do not have the right to use them before men do.' (R14, female, social worker professional working in the non-governmental organization Xenoni, 30-35 years old)

Therefore, I think that those men who have a drug using female partner may benefit from their partners' drug use significantly. Firstly, because women's dependence gives them more power and dominance over them, secondly, because they get additional help during the drug obtaining process and may even get financial support from the woman who is ready to be involved in sex work in order to get money and pay for drugs; and thirdly, because in a male dominated system, violence against women is widespread; violence against women who are drug dependent is even justified.³⁴⁵

Therefore, the whole male dominated system, which even justifies violence against women who use drugs, creates an ideal opportunity for men to *exercise* double power and control over women, who has drug use problems. One interesting point I would like to outline before moving on to the next important issue touched upon by the experts regarding women and drug use is the way how the experts described and characterized women and their drug use activities. The experts expressed an opinion that a male with drug dependence, who has a wife or a girlfriend, must be the initiator of her drug use and must be forcing her to use or continue to use drugs. The experts formulate this opinion based on their own experience, since female patients who approach them for assistance are, in most cases, married to male drug users. But why not assume that the experts' explanation is dictated by the Georgian traditional attitudes according to which a woman is a passive and obedient being who does not show initiative

³⁴³United Nations Office on Drugs and Crime (2006), "HIV/AIDS Prevention and Care for Female Injecting Drug Users." Available at: http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf, Accessed: 5.12.13.

³⁴⁴Women's Health Victoria (2008). "Women and Drugs." Available at: http://whv.org.au/static/files/assets/030e652b/Women_and_drugs_GIA.pdf, Accessed: 5.12.13.

³⁴⁵Pinkham S, Malinowska-Sempruch, K. (2007). Women, Harm Reduction and HIV, New York: International Harm Reduction Development Program of the Open Society Institute. Available at: <http://www.hivpolicy.org/Library/HPP001574.pdf>, Accessed: 26.09.13.

herself and carries out deviant behavior (in this case, drug use) only if a man demands or orders her to do so, because she knows that she must obey a man's demand? Of course, we must acknowledge that the explanation provided by the experts is not far from the reality in Georgian patriarchal families.

The majority of Georgia's population supports the opinion that all important decisions in the family must be made by the man.³⁴⁶ But if we assume that a woman may also be interested in drugs and want to taste the 'forbidden fruit' and have more access to narcotic substances through a male who uses drugs, then the explanation provided by the experts, according to which the man is the main cause, may no longer be a good argument to explain all the cases. In this case, the man turns out to be the main '**means**' rather than the main '**cause**' of experimenting with and searching for drugs. It is really not difficult to argue that women in Georgia are mostly passive and submissive in relation to men, but we cannot deny either that representatives of both genders may have a desire to taste the 'forbidden fruit' and that women, like men, may also use drugs on their own initiative and have a drug-using partner, but still have the role of an active individual responsible for her desires and actions rather than that of a passive and submissive person when she uses drugs. However, the studies as well as the expert interviews with my respondents clearly demonstrate that sooner or later, even an active, independent female who uses drugs who is confident in her actions still becomes a victim of the patriarchal system, however strong she may be. And some day or another, a strong and independent woman who uses drugs also encounters problems related to some form of violence. Studies demonstrate that violence and illicit drug use are strongly linked³⁴⁷ and that involvement in drug use can increase the risks of being a victim of violence, while experiencing violence can increase the risks of initiating illicit drug use.³⁴⁸

The Georgian experts discussed the issue of violence in details and mentioned that, apart from male partners, another important reason for female drug use appears to be violence. In some cases women start using drugs because they have experienced domestic violence and abuse.

'The physical or sexual abuse of women is a widespread problem in Georgia. A lot of international studies show that women with substance use problems are more likely to have experienced physical or

³⁴⁶Japaridze, E.(2012). Assessment of the Gender Equality Policy in Georgia by Women's Organizations, Research Paper. Available at: http://css.ge/index.php?lang_id=ENG&sec_id=52&info_id=463, Accessed: 12.03.13.

³⁴⁷World Health Organization.(2006). "Alcohol and Interpersonal Violence Policy Brief." Geneva, World Health Organization

³⁴⁸ Ibid.

sexual abuse than addicted men. I think that, in the case of Georgian women, physical abuse and domestic violence is one of the very important reasons which stimulates women's desire to use drugs and escape from the horrid reality. A history of violence can increase the risk of substance use, post-traumatic stress disorder, or other mental health problems.' (R9, female, researcher working at Alternative Georgia, 35-40 years old)

Experts mention that women use drugs in order to escape from violent reality because they experience domestic/interpersonal violence; other experts note that women start to use drugs for fun and to share the same emotions and the feeling of equality with their drug using partners and then their drug use turns into violence and abuse. But it is evident that in both of these described cases the main difference in the case of male and female drug experimentation and drug use is related to experiencing violence.

Also, the literature demonstrates that women very often use drugs as a coping mechanism in order to deal with the distress associated with being a victim of violence.³⁴⁹ The literature also demonstrates that, mostly, women tend to be victims of physical and sexual violence³⁵⁰ and that violence very often appears in case of women's substance use.^{351/352} Moreover, research figures show that a high number of women in drug treatment have suffered recent domestic abuse and that approximately half of men in drug treatment admit to perpetrating such abuse.³⁵³ Studies covering domestic violence issues demonstrate that approximately two-thirds of women who are using services for women experiencing violence report to have started to use drugs because of experiencing domestic violence.³⁵⁴ At the same

³⁴⁹ Moran, P., Vuchinich, S., Hall, N. (2004). "Associations between Types of Maltreatment and Substance Use During Adolescence." *Child Abuse and Neglect*, 28, pp. 565-574.

Clark, W. (2001) "Violent Traumatic Events and Drug Abuse Severity," *Journal of Substance Abuse Treatment*, 20, pp. 121-127.

³⁵⁰ National Center for Injury Prevention and Control (2010) "National Intimate Partner and Sexual Violence Survey." Available at: http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf, Accessed: 17.09.13.

³⁵¹ Wallen, J. (1992). "A comparison of Male and Female Clients in Substance Abuse Treatment," *Journal of Substance Abuse Treatment*, 9, pp. 243-248.

³⁵² Boyd, C., Blow, F., Orgain, L. S. (1993). "Gender Differences among African-American Substance Abusers," *Journal of Psychoactive Drugs*, 25(4), pp. 301-305.

³⁵³ Weisman, M., Berman, M.E., Taylor, S.P. (1998). "Effects of Clozapate, Diazepam and Oxzegan on a Laboratory Measurement of Aggression in Men," *International Clinical Psychopharmacology*, 13, pp. 183-188.

³⁵⁴ Parkes, T., Welch, Besla, K., Leavitt, S., Ziegler, M., MacDougall, A., Armstrong, S., La Combe, B., LeClaire, M., Taylor, N., Cory, J. (2007). "Freedom from Violence Tools for Working with Trauma, Mental Health and Substance Use." Ending Violence Association of BC. Available at: <http://www.endingviolence.org/files/uploads/FreedomViolenceIntro.pdf>, Accessed: 18.09.13.

time there is evidence that substance use and/or mental health concerns can create a vulnerability to violence and that the pre-existence of these conditions may exacerbate the effects of abuse.³⁵⁵

Moreover, violence towards women who use drugs is justified and the majority of society even thinks that drug-dependent victims deserve to be treated disrespectfully.³⁵⁶ Drug use exposes women to harsh judgment from society and justifies the batterers³⁵⁷ and worsens women's life conditions significantly. Studies make it obvious that the perpetrators of violence are searching for arguments and justifications for their violence. Those men who commit violence against their female partners often perceive that their partners are failing in their responsibilities and therefore deserve to be treated violently. According to Dobash and Dobash (1979), these responsibilities are about sex, money and home-making.³⁵⁸ Therefore, women often apply men's perception and expectations to themselves and react to their 'failures' with guilt and shame and believe that they deserved this kind of violence because they have not fulfilled those duties which were expected of them.

Consequently, women often even believe that they deserve to be beaten. The Dobash study made it clear that 31 percent of the women participating in the study thought that in some circumstances a man has the right to hit his wife; for neglecting the children; sleeping around or for failing to care for her husband.³⁵⁹ And when women's drug use is added to the above-mentioned situation, it is clear that the batterer has additional argument to treat his partner violently and diminish her rights. For example, research conducted in Georgia demonstrates that over 80 percent of women who use drugs have suffered violence in their homes.³⁶⁰

The issue of stigma reflected by the professional helpers

As the experts note, one of the characteristics of women with drug dependence is that their addictive behavior often remains unnoticed by their wider environment (including their family members) for a rather long time. The experts say that females are usually distinguished by their care and accuracy in the process of looking for drugs. Most of them prefer buying psychotropic tablets in a drugstore and avoid

³⁵⁵Gatz, M., Russell, L.A., Grady, J., Kram-Fernandez, D., Clark, C., Marshall, B. (2005). "Women's Recollections of Victimization, Psychological Problems, and Substance Use," *Journal of Community Psychology*, 33(4), pp. 479-493.

³⁵⁶Pinkham S, Malinowska-Sempruch, K. (2007). *Women, Harm Reduction and HIV*, New York: International Harm Reduction Development Program of the Open Society Institute. Available at: <http://www.hivpolicy.org/Library/HPP001574.pdf>, Accessed: 26.09.13.

³⁵⁷ Ibid.

³⁵⁸Dobash, R.E. and Dobash, R. (1979). "*Violence against Wives*." New York: Free Press

³⁵⁹Ibid.

³⁶⁰Step to the Future (2012). "Violence in the Families of Drug Using Women", Georgia, Gori, p. 11 (unpublished).

problems with drug dealers and the police and generally, their drug dependence often remains unnoticed. They can and do conceal it for a long time.

'Female drug users can conceal their drug use for a long time. It is very difficult to imagine that a woman from our circle – our wife, friend, sister, cousin, or neighbor – uses drugs. They hide their addiction and that leads to very negative consequences.' (R7, male, medical doctor/director of the Georgian Harm Reduction Network, 40-45 years old)

The Georgian experts agree that society exhibits considerable stigma and intolerance towards females with drug use problems, *'because a female drug addict violates the stereotypical role established for a woman'* (R3, male, psychiatrist, professional from medical center Uranti, 50-55 years old), and females with drug use problems try to conceal the problem of their drug dependence for as long as possible in order not to be ostracized from society and not to become a victim of stigma.

'Due to our social and cultural values, women are, first of all, seen as mothers, housewives, and caregivers. A woman's addictive behavior causes considerable irritation and disgust in men. Male drug users know that drug users' thinking is entirely focused on how to obtain drugs. For a drug addict, taking drugs is so important that all the other values become worthless compared to it. A woman who uses drugs can forget all her responsibilities – the responsibilities of a wife, housewife, mother, sister...' (R1, female, psychotherapist having her own private practice, 50< years old)

As discussed by Otiashvili et al (2013), Georgian society mostly idealizes a woman's role and considers her 'destiny' to be a caring wife and mother. Therefore, substance use, which is viewed as a serious deviation from these traditional societal norms, contributes to the acceptance of substance using women as morally weak, irresponsible, and negligent.³⁶¹ As Otiashvili et al (2013) argue, society's negative attitudes influence a woman's perception of herself and lead to extreme self-stigmatization and low self-esteem. Most often, women with substance abuse problems feel guilty and ashamed of their behavior and therefore they try to conceal it from the family members, friends, and even from healthcare providers.³⁶² As discussed by Frisaufova (2012), drug use in many ways contradicts what is seen as the social ideal of feminine behaviour and therefore negative moral judgements and stereotypes

³⁶¹Otiashvili,D.,Kirtadze, I., O'Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012) "Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers" International Journal of Drug Policy, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

³⁶²Ibid.

are more likely in the case of drug using women than men.³⁶³ Additionally, Ettore (1992) argues that, because of the socially accepted norms, women are more stigmatised for drug use activity.³⁶⁴ Women who use drugs are mostly stereotyped as being bad women and for failing as mothers, partners, and guardians of moral standards.³⁶⁵

As Fiske (1992) explains, ‘stereotyping operates in the service of control.’³⁶⁶ Stereotypes involve perceptions as to how one is expected to behave, what they are ‘supposed to’ like, and the types of activities that they are ‘fit’ to do. Examples include the ideas that women should be good caregivers, men should be strong, etc., and therefore, those women who do not fit in the role of a good caregiver are in turn stereotyped as failing women and mothers. Fiske (1992) compares this type of stereotype to a ‘fence’ that surrounds and controls social interactions. Stereotypes, therefore, reinforce the power that one group exerts over another through limiting the options of the stereotyped; in this way stereotypes maintain power and power maintains stereotypes. Considering that stereotypes constitute a dimension of stigma, any conceptualization of stigma must entail the concepts of power and control, which are inextricably intertwined. And when analyzing the problem of female drug use, we face both - power and control over women who are stereotyped as being failing at ‘ideal women’ because of their drug use.

More than half of the interviewed experts used the definition of ‘twice stigmatized’ while referring to women with substance abuse problems. The experts explained that women who are drug-dependent are not only marginalized by the society but are also rejected by drug-dependent men.

‘Even male drug users are disposed to judge female drug addicts very aggressively! Women with drug use are rejected by everyone!’ (R20, male, director of non-governmental organization New Vector, 45-50 years old)

The fact that society is very negatively disposed towards individuals with drug use problems is no surprise. Many examples of society’s negative attitudes towards drug use and users were demonstrated in different studies reviewed in the literature part. One good example of Georgian society’s intolerance

³⁶³Frišaufová M. (2012). “The Female Drug User as a ‘Victim’ or ‘Villain’ and the Implications for Social Work.” Social Work and Society, 10 (1). Available at: <http://www.socwork.net/sws/article/view/313/657>, Accessed: 11.09.13.

³⁶⁴Ettore, E. (1992) “*Women and Substance Use*”. London: Palgrave Macmillan.

³⁶⁵Frišaufová M. (2012). “The Female Drug User as a ‘Victim’ or ‘Villain’ and the Implications for Social Work”. Social Work and Society, 10 (1). Available at: <http://www.socwork.net/sws/article/view/313/657>, Accessed: 11.09.13.

³⁶⁶ Fiske, S (1992). “Controlling other People. The Impact of Power on Stereotyping.” Available at: http://www.radford.edu/~jaspelme/private/gradsoc_articles/stereotypes%20and%20prejudice/Power_and_stereotypes.pdf, Accessed: 17.12.13.

towards individuals with drug use problems is also confirmed by an opinion poll conducted in 2008, according to which 90 percent of Georgians acknowledge that they would not like to have a drug addict as a neighbor.³⁶⁷ In addition, Georgia's repressive drug policy (see detailed information about drug policy in Chapter 3) contributes to the formation of intolerance and stigma.³⁶⁸

However, I was surprised to discover that those men who use drugs and are stigmatized show aggressiveness and intolerance towards women with drug dependence problems. Similar sentiments are expressed by Kirtadze et al (2013), who argues that Georgian women are twice stigmatized, once by the society that views them as failing women and again by their male drug-using counterparts.³⁶⁹ Some experts explained the particular aggression of males with substance use problems towards women who use drugs with the argument that females with drug use problems are often involved in prostitution. This means that women who use drugs once are stigmatized as failing as 'good/ideal' women and secondly are carrying the stigma attached to prostitution. Studies show the strong link between prostitution and drug use among women and demonstrate that for many women drugs are the reason they became involved in prostitution, and working on the streets appears to be a way to get money for drugs.³⁷⁰ Women involved in prostitution and substance use experience the impact of 'double stigma' as a result of using drugs and involvement in prostitution.³⁷¹

According to the opinions of the experts, the disproportionate levels of stigma and discrimination attached to women with substance use problems creates significant barriers to accessing both treatment and harm reduction services. Women are afraid of being forcibly removed from their homes, ostracized by family, friends and the broader community and of having their children taken away, regardless of whether or not they fulfill their parental responsibilities. Because of this stigma, women prefer to conceal their drug use problems as long as possible and the issue of refusing help and professional support deteriorates their health and life conditions significantly.

³⁶⁷ European Values Study 2008 (EVS). Available at: <http://www.europeanvaluesstudy.eu/evs/data-and-downloads/>, Accessed: 11 February 2013.

³⁶⁸ Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18 March 2013].

³⁶⁹ Kirtadze, I., Otiashvili, D., O'Grady, K. E, Zule, W, Krupitsky, E., Wendee M., Jones, H.,E.(2013) "Twice Stigmatized: Provider's Perspectives on Drug-Using Women in the Republic of Georgia", *Journal of Psychoactive Drugs*, 45(1), p.1.

³⁷⁰ Drug Scope and AVA "The Challenge of Change: Improving services for women involved in prostitution and substance use." Available at: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/Challenge%20of%20change_policy%20briefing.pdf, Accessed: 19.12.13.

³⁷¹ Ibid.

However, before we move to the next discussion topic regarding the treatment needs and barriers women with substance use problems face, I would like to focus my attention on the issue of how a number of the experts interviewed by me described and explained the aggression towards women with dependence problems. Some of the interviewed experts used the argument that, in most cases, women who use drugs lose self-respect and dignity much more quickly than men do. Due to women's emotional nature, they come under the influence of narcotic substances very easily, and openly demonstrate their sexual desires. Accordingly, in a woman who is drug-dependent, a male with drug dependence sees a dishonest woman who has lost her self-respect and is ready to do anything, and his belief that this is socially unacceptable for a woman results in his aggression towards her:

'Female drug users lose self-respect more easily than male addicts. They often offer themselves sexually for money, and many of them even become sex workers. When women drop from the social ladder, it is much more difficult for them to achieve further adaptation than it is for men.' (R19, male, professor/narcologist, professional working in the Research Institute on Addiction, 45-55 years old)

"Women who are dependent on drugs lose their dignity; they lose self control, become sexually promiscuous..." (R15, female, psychiatrist, professional working at the Research Institute on Addiction, 35-40 years old)

The explanation that *'female drug users lose their dignity more easily than male addicts,'* which was offered by several respondents, may indicate an extremely negative stereotype that female users are sexually promiscuous because of their drug or alcohol use.³⁷² When explaining the signs characteristic of women's addiction, several experts noted that, in general, a woman is more emotional than a man and, for this reason, narcotic substances affect her psyche much more negatively.

'Women are more emotional than men, and their addiction is more complicated. Drugs change a woman's psyche radically' (R3, male, psychiatrist, professional from medical center Uranti, 50-55 years old)

In both of these cases, the experts reveal an inclination towards gender stereotyping by referring to the female addicts' emotional nature and loss of dignity. This generalization mirrors the discriminatory attitudes towards females with drug-use problems and is reminiscent of the point made by Ridlon (1988) that, according to widely spread stereotype, alcohol use causes loosening of sexual morals in

³⁷² Copeland, J. (1997). "Barriers to formal treatment among women who self managed change in addictive behaviors," *Journal of Substance Abuse Treatment*, 14(2), pp. 183-190.

women and that drunken women are most often sexually ‘available.’³⁷³ Ridlon (1988) named this fact a ‘double standard’ and, due to the ‘double standard,’ the level of stigma towards women who use alcohol or other drugs is much more severe. In my opinion, it is worthwhile taking into account that drug experts and medical staff themselves are part of the part of society that is often unable to conceal its negative attitude towards females with drug use problems. Even the explanations that several experts gave me revealed the deep-set stereotypes regarding a woman’s nature and showed the experts’ predisposition to negatively judge females who are drug-dependent. For example, some of the experts noted that psychological dependence on drugs develops more often in women than in men, which they blamed on women’s emotional nature:

‘Due to the emotional nature of women, the psychological dependence on illicit substances develops faster and in more severe forms in women than in the case of men. Working with women is very difficult and requires a lot of patience.’ (R5, female, psychiatrist, professional working at the Research Institute on Addiction, 40-50 years old)

The statement regarding women’s emotional nature is very general and the experts did not explain to me why it was difficult to work with women. The statement implies that women are much more emotional than men, and it is also much more difficult to work with a cohort of women. The statement could be attributed to the widespread stereotype regarding women’s emotional nature and placing all women in the ‘weaker sex’ category. However, as Chesler (2005) argues, women are socially marked as the ‘weaker’ sex not just physically, but mentally, and therefore their illnesses are also attributed to their emotional nature and not physical.³⁷⁴ And this is exactly the gender biased inclination in the case of my interviewed experts too. A number of the experts think that it is difficult to work with women who use drugs, and perhaps they are right. But I find the arguments provided by the experts to substantiate this claim very stereotyped and gendered. Those experts that talk about the difficulty of working with women cite women’s emotional nature as the only cause of such difficulties and problems. Chesler (2005), in his book, clearly indicated and analyzed how the experts’ stereotyped talk about women’s emotional state constitutes a serious problem, and how the social factors are grossly disregarded at the same time, which plays an important part in aggravating women’s situations and in working with them.

³⁷³Ridlon, F. V. (1988). *“A Fallen Angel: The Status Insularity of the Female Alcoholic.”* Lewisberg: Bucknell University Press, p.25.

³⁷⁴Chesler, P. (2005). *“Women and Madness.”* Palgrave Macmillan.

When talking about working with female users, a large number of the Georgian experts overlooked a number of problems, such as domestic violence, sexual violence, etc., which significantly aggravates women's mental health and is the reason women are already in quite a poor state when they approach health institutions for treatment or for other types of service (see detailed information on women-oriented services in Chapter 1). Studies of women with drug problems have revealed a dramatic connection between domestic violence, childhood abuse, and substance abuse and have shown that the problem of violent victimization deeply affects women's general conditions.³⁷⁵ And when working with women it is of immense importance to take the problem of violence and other social factors such as sexism, gender inequality, subordination, and poverty into consideration and so become free from the biological determinism and be focused only on individual pathology.

The analysis of the explanations offered by the experts allows me to think that the experts themselves, consciously or unconsciously, make a very strict and stereotypical distinction between genders in terms of the desire to use drugs. They rule out the individual, independent nature of a woman who is responsible for her actions and desires, subjecting her, as a passive object, to an active, influential, and strong man. They explain a woman's diseases and deviations by her emotional nature. The explanations offered by the experts emphasize the traditional notions of the 'place' and 'nature' of the Georgian woman, and, finally, we encounter the stereotypical ideology according to which a woman is an irrational and weak being.³⁷⁶ However, this definitely should not be surprising, because the explanations that have been offered were formulated under the influence of the culture and traditions in which these experts live and work. The professionals repeat the gender order; they tend to interpret what they see in a gendered-stereotypic mode.

One important issue I would like to stress is related to the fact that both male and female drug experts' explanations are very similar, and on the whole, neither male nor female drug experts (except for a few individuals) seemed to have gender sensitive attitudes towards females with drug use problems. This could be explained by the fact that they just lacked the gender awareness regarding drug use issues and female drug use. The problem regarding a gender-determined approach in the drug treatment sphere is evident in the study by Kirtadze et al. (2013), which examined attitudes and perspectives of 34 health service providers in Georgia which worked with women with drug dependence. Most participants of

³⁷⁵SAMHSA.(1997). "*Substance Abuse Treatment and Domestic Violence.*" Washington, DC: SAMHSA.

³⁷⁶Oliver, K., Pearsall, M. (1998). "*Introduction: Why Feminists Read Nietzsche,*" in *Feminist Interpretations of Friedrich Nietzsche*, Penn State Press, pp. 1-4.

the afore-mentioned study reported that drug dependence in women is much more severe than in men and expressed less tolerance towards women, characterizing them as bad mothers and failing wives.³⁷⁷

My main goal, for a researcher working on gender and women's issues, is not to criticize the existing ideology, but to highlight the essence of the problem clearly. I think that, with such a stereotype in place, it is no surprise that the experts whose assistance women seek, from the very beginning, have the attitude that it will be much more difficult to work with women service users. But what if the difficulty of working with women is caused by social barriers created by our society, such as the fear of losing a child, family, and loved ones, rather than by their emotional state? It still remains a fact that these barriers are more frequent and stronger in the case of women than in the case of men, and they may be the reason why men find it less difficult to go to treatment clinics, have more belief that their families will stand by them, and feel less ostracized from society.

Gendered treatment protocols

Recent studies conducted on drug use in Georgia recognize a specific problem of the female drug user population. There is a serious discussion that society's discriminatory attitudes, and the greater social stigma attached to females dependent on drugs, are the most important barriers for women in searching for treatment and assistance. For example only 1.3 percent of women (11 of 841 women) with drug use problems received drug treatment (detoxification) in six drug treatment clinics of Georgia in 2008. Between 2005 and 2012 only 42 women underwent methadone treatment and half this number (21 women) was in-patients in methadone programs in September 2012. As it turns out, women involved in methadone therapy accounted for 1.5 percent of all methadone patients in 2012 (21 women out of 1,400 methadone patients).³⁷⁸ Due to the severe stigma, women with drug use problems are invisible and represent the hidden population; they do not undergo treatment anywhere, do not use any services, and are not registered officially anywhere and so, presumably, the real number exceeds the data given here to a great extent.³⁷⁹

³⁷⁷Kirtadze, I., Otiashvili, D., O'Grady, K. E., Zule, W., Krupitsky, E., Wendee M., Jones, H., E.(2013). "Twice Stigmatized: Provider's Perspectives on Drug-Using Women in the Republic of Georgia," *Journal of Psychoactive Drugs*, 45(1), p.1.

³⁷⁸Lomidze, G. (2012). Research conducted within the framework of the project 'Femina'. Gori: Union 'Step to the Future' (Unpublished).

³⁷⁹Kirtadze, I., Otiashvili, D., O'Grady, K.E., Zule, W., Krupitsk, E., Wendee, M., Jones, H.E.(2013). "Twice Stigmatized: Provider's Perspectives on Drug-Using Women in the Republic of Georgia", *Journal of Psychoactive Drugs*, 45:1, pp. 1-9.

Several studies demonstrate different reasons for women's failure rates in treatment programs. For example, Brady and Ashley (2005) report that women are more likely than men to experience economic barriers when seeking treatment. They are also more likely to have trouble finding the time to attend regular treatment sessions because of family responsibilities and are more likely to have problems related to transportation to medical establishments.³⁸⁰ However, the most significant problem regarding women's low attendance is related to male-oriented treatment, which does not consider women's specific needs and problems.³⁸¹

The experts interviewed in my study outline that females with drug use face more complicated barriers in treatment than men usually do; they focus their attention on such problems as lack of childcare assistance or a safe environment for women. In the experts' opinion, the absence of appropriate services for women makes it very difficult for them to go to a center for replacement therapy, or any other type of rehabilitation establishment. For this reason, women either do not go to medical establishments or, if they do so in extreme circumstances, they have to overcome a great deal of discomfort, fear, and difficulties, which, in itself, decreases their motivation and desire to recover.

'The replacement therapy in Georgia is not women-oriented; it doesn't provide on-site childcare or assistance for women with children.' (R12, female, psychologist, professional working in the non-governmental organization Xenoni, 45-50 years old)

'Most commonly, drug using women are not financially independent and depend entirely on their male partners. For this reason, it is difficult for them to obtain the money needed for treatment when, for example, their male partners either do not want them to quit using drugs or they are not drug users and the women do not want to let them know about their addiction. Besides, women who have no-one to take care of their young children find it very difficult to visit a medical establishment. If we add stigma, fear, discrimination, and aggression to the afore-mentioned problems, it is practically no surprise that these women may conceal their drug problem.' (R9 female, researcher working at the non-governmental organization Alternative Georgia, 35-40 years old)

As the experts explain, when a woman goes to a center for replacement therapy, she automatically has to let the other patients there know about her illness, because there is, for example, only one entrance to

³⁸⁰Brady, T.M. and Ashley, O.S. (2005). "Women in Substance Abuse Treatment: Results From the Alcohol and Drug Services Study (ADSS)." DHHS Pub. No. SMA 04-3968, Analytic Series A-26. Rockville, MD: The Substance Abuse and Mental Health Services Administration, the Office of Applied Studies.

³⁸¹Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995). "Gender difference in drug addiction and treatment: Implications for social work intervention with substance-abusing women," *Social Work*, 40(1), pp. 45-54.

the treatment center and all the male patients who stand *'in the queue for their daily dose of methadone see her'*(R9 female, researcher working at the non-governmental organization Alternative Georgia, 35-40 years old)

As was already noted, males with substance use problems are distinguished with their aggressiveness and non-acceptance of female users, and women are afraid of this aggression. The experts recalled several cases when men displayed such an aggressive and insulting attitude towards females with drug use problems that the latter had to leave the treatment center to avoid dramatic consequences. For women, lack of physical safety inside and outside the treatment program setting can be a barrier to entering and remaining in treatment.

'We had some very unpleasant cases when female users left the center because of aggression from male addicts. The men addressed them with very obscene language, abusing them both verbally and physically. It is quite common for men to touch women physically and try to harm them.'(R17, male, professor/narcologist, professional working in the Research Institute on Addiction, 45-55 years old)

The experts say that women with substance use problems are especially afraid of encountering acquaintances in a substitution therapy center, who will stigmatize them because of their drug use.

As the methadone substitution center has only one entrance and one common waiting area, all the methadone program participants have to stand together in line in the waiting area and therefore the likelihood of meeting a lot of acquaintances and friends is very high. For this reason, a lot of women refuse to use the service of substitution therapy. Some of the experts also note that in some cases, women may be forbidden from leaving their homes to go to a treatment center.

'Going to a medical establishment implies acknowledging your status and making your drug dependence visible to other people. Tbilisi is a small city and it is very likely that someone you know will see you. And women are afraid of this.' (R8, female, social worker working at medical center Uranti, 20-25 years old)

'Because relationships play such a significant role in women's lives, women living with a substance-using partner may be deterred from seeking treatment for fear of losing the relationship.' (R4, female, psychotherapist having her own private practice 50 < year old)

It is true that the experts highlight the existence of women-oriented services, but by this they imply child-care service, a separate entrance for women and safe environment. The above issues are clearly important, and their resolution still remains a priority, but the scope of the problem is not limited to

these topics. Many experts believe that there should be a separate treatment facility for women where they will be in a better environment. They also think that in similar institutions women would feel much safer and protected from male violence and aggression. Furthermore, there is less possibility of meeting a male acquaintance who they do not want to see and reveal their drug addiction to.

'It would be very good to have a center designed only for women, in Georgia. This would resolve many problems related to discrimination of female drug users.' (R16, counselor/epidemiologist, director of non-governmental organization Step to the Future, 45-50 years old)

However, the majority of experts overlook two important issues. The first is that women-oriented services do not imply only a separate facility or child-care services. The experts did not focus on a number of those specific problems that are associated with women with drug dependence, such as violence, and the condition aggravated by violence. During the interviews the experts also failed to mention the structural problems concerning the lack of skills of working with women. Many studies have proved that it is important to take into account the effect of domestic violence when working with women service users. Mostly, the treatment delivery services do not acknowledge the importance of considering the impact of domestic abuse on delivering treatment that is effective, accessible and meets the needs of women service users.³⁸² It is a fact that female service users are the victims of violence and, as well as interpersonal/domestic violence, women with drug use problems face structural violence as well. The problem of structural violence is visible when women suffering from domestic violence are denied help and access to shelters because of being suspected of using drugs. Studies show that domestic violence victim shelters fail to address substance use problems. Many services dealing with domestic violence lack the training and resources to meet the specific needs and requirements of women drug users. Furthermore, research demonstrates that women may be denied assistance and not accepted if they are suspected of using drugs.³⁸³

Harm Reduction International reports in its paper 'Violence Against Women Who Use Drugs, and Access to Domestic Violence Shelters' (2013) that women suffering from violence and addiction find it

³⁸² Galvani, S., Humphreys C. (2007). "The Impact of Violence and Abuse on Engagement and Retention Rates for Women in Substance use Treatment." Available at:

http://www.nta.nhs.uk/uploads/nta_the_impact_of_violence_and_abuse_women.pdf, Accessed: 17.09.13.

³⁸³ UNODC, (2004). "Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned." Available at: http://www.unodc.org/pdf/report_2004-08-30_1.pdf, Accessed: 17.12.13.

hard to use anti-violence services.³⁸⁴ They are afraid of being entered into the national drug registers and of losing their children or being left out of work.³⁸⁵ But there are also cases where countries forbid drug abusing women to apply to women shelters. The report lists a few countries where state shelter regulations deny shelter to those female victims of violence who use drugs.

Let's consider some comparative views. For example, Turkey, where state shelter bylaws clearly forbid drug using women to enter the shelter. In some countries local authorities, rather than state authorities, regulate the access of female drug users to shelters. In Switzerland, Cantonal laws determine when women are admitted to shelters; generally, under these laws, drug using women cannot use shelter services. Female drug users are not allowed into US or UK shelters either. In Latvia, local municipalities determine whether female victims of violence can apply to a shelter, and some municipalities do not even have a crisis center for such women. In Latvia, women who consume alcohol or illegal substances are removed from shelters. In Kazakhstan, the law does not provide for the use of violence services, and victims of domestic violence cannot use free legal aid.³⁸⁶ In Slovenia it is not formally regulated and is therefore very arbitrarily decided. Women who use drugs are unwanted and might be refused entry to the women's shelter- or they might be accepted, it depends very much on the staff working in the shelter. However, Macedonian laws provide for the use of violence services and shelters for women, but according to local NGOs, drug using women usually cannot access shelters or find accommodation. The situation is similar in Russia. Eurasian Harm Reduction International maintains in its report that female drug users, particularly those with children, are not allowed into shelters across Eastern Europe and the Caucasus.³⁸⁷

There are no reliable data regarding female victims' exclusion from Georgian shelters because of drug use experience. However, as the regulations of the Georgian State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking state, those beneficiaries who use alcohol or other drugs in the shelter may be excluded from the shelter.³⁸⁸ This means that the exclusion of female drug users

³⁸⁴ Harm Reduction International (2013). "Violence against Women who use Drugs and Access to Domestic Violence Shelters." Briefing Paper. Available at: http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03_.13_.pdf

³⁸⁵ Ibid.

³⁸⁶ Ibid.

³⁸⁷ Harm Reduction International (2013). "Violence against Women who use Drugs and Access to Domestic Violence Shelters." Briefing Paper. Available at: http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03_.13_.pdf

³⁸⁸ Available at: http://www.atipfund.gov.ge/images/stories/pdf/filialebi/gori_dzaladoba.pdf, Accessed: 17.12.13.

from the shelter forces women who use drugs to remain in violent relationships or face potential homelessness, compromising their safety and violating their right to live free from violence.³⁸⁹

At the same time, social care services, which provide treatment and support for women who use drugs, also lack the knowledge and capacity to deal with the domestic violence cases of their clients.³⁹⁰ For example, the study conducted in Georgia by Otiashvili et al (2013) shows that the vast majority of substance use treatment and low-threshold programmes lack the knowledge and skills to address the unique needs of women, lack the comprehensive knowledge of gender-specific characteristics and are male-oriented.³⁹¹ According to the briefing paper ‘Violence against Women who use Drugs, and Access to Domestic Violence Shelters (2013), exclusions from accessing shelters are rarely required by law and most often women who use drugs are denied access to domestic violence services based on the decisions of care workers and/or policies of individual shelters.³⁹² It means that there is a large gap creating a serious structural problem for women who may be both drug users and victims of violence. These kinds of structural barriers deteriorate the health and life conditions of women who use drugs and may be in need of help and support. According to the Committee on the Elimination of Discrimination against Women, the absence of such support and arrangements in domestic violence shelters, ‘constitute[s] a violation of the applicant’s human rights and fundamental freedoms, particularly her right to security of person.’³⁹³

Therefore, when discussing the problems of female service users, it is important that the institutions providing services to these women see the problem from a gender point of view, because, if the services are not women-oriented and the personnel trained to provide qualified assistance, a separate facility for women and so called logistical problems will not solve the issues of women with drug use problems. There is no denying that improved services and a separate rehabilitation establishment for women will provide a partial solution to the problem of the registered female users who are currently undergoing treatment. It will make it easier for them to get involved in the treatment process and

³⁸⁹Lowia Coalition for Domestic Violence, (2012).“Service Delivery Standards for Member Programs.” Available at: <http://www.icadv.org/pdf/icadv-service-delivery-standards-march-2012.pdf;-a>, Accessed: 17.12.13.

³⁹⁰ Harm Reduction International (2013).“Violence against Women who use Drugs and Access to Domestic Violence Shelters.” Briefing Paper. Available at: http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03_.13_.pdf, Accessed: 17.12.13.

³⁹¹Otiashvili,D., Kirtadze, I., O’Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012). “Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers.” International Journal of Drug Policy, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

³⁹² Harm Reduction International (2013).“Violence against Women who use Drugs and Access to Domestic Violence Shelters.” Briefing Paper. Available at: http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03_.13_.pdf, Accessed: 17.12.13.

³⁹³Ibid.

remove the fear of meeting men and acquaintances in the establishment, and there will be fewer cases of aggressive and insulting acts against women on the part of men. But the existence of a separate establishment for women is no guarantee that it will provide professional assistance towards a better result regarding the reduction of the level of stigma and discrimination in society. Firstly, it is of crucial importance to train and qualify the staff which will work with women.

Secondly, it is necessary to facilitate the improvement of the system where women-oriented services mutually cooperate and do not create the kind of gap that exists between various violence protection services and other services of drug-dependent persons. Solving these issues will definitely reduce those strategic barriers that female users encounter. But, in my opinion, a different kind of work has to be carried out in order to reduce the level of stigma and discrimination; a separate facility for women service users may not only reduce but even increase the existing stigma against women service users in society.

Taking into account that going to and registering in this center will be related to immediately being labeled as a drug addict, as it is the case with other rehabilitation establishments. And society will particularly stigmatize all those women who are registered at this center. One of the most important steps in the struggle against stigma and discrimination is not only improving/developing the existing services for women as indicated by my respondents, but also by holding educational and informative events, which the experts did not mention in conversations with me.

I think that Georgian society will have a more adequate attitude to the problem of female drug use peculiarities if it receives comprehensive and reliable information about drug dependence in general, separates drug dependence from criminal activity, and realizes that severe stigmatization and discrimination of women leads to deplorable consequences.

Conclusion

This chapter summarizes the results of in-depth interviews with experts aimed at: (i) ascertaining the level of knowledge currently existing in Georgia about the differences in the addictive behavior of males and females with drug use problems, (ii) finding out the gender-specific problems individuals with drug use problems encounter based on expert experience, (iii) identifying difficulties, barriers the individuals with drug use problems of different genders face and (iv) analyzing the solutions the experts offer for successful treatment of women who are drug-dependent.

This analysis of the research shows that, in the opinion of the experts interviewed, individuals with drug use problems of different genders in Georgia may differ to a great extent in how and why their drug use begins and how it proceeds, as well as in their paths to recovery. In this respect, it is also noteworthy that different attitudes of society towards males and females with drug use problems (which the experts talked about in their interviews) stem from the ancient traditions and customs of our culture. It seems that men in their teenage years are mainly motivated by solidarity towards a group. In order not to be different and ostracized from their circle of friends, with whom they spend a lot of time and who are authorities for them, men imitate, and behave in a way that is acceptable within this group. In the case of females, experts offer an absolutely different explanation; most of them blame male drug using partners for giving the first injection to women.

The experts believe that women are more likely to suffer from serious negative effects of addiction and to experience those negative effects faster than men. Women are less likely to seek addiction treatment than men and will encounter more social and structural barriers on their ways to treatment. At the same time, women with addiction may be more vulnerable to starting and remaining in unhealthy relationships, and they may receive less support in the recovery process. In addition, women find themselves more isolated from society and have more difficulties in managing the situation.

The experts also acknowledge the problem of stigma towards women with substance use and the weakness of female-oriented services. Due to increased aggression and discrimination towards females with drug use problems, women find it more difficult to go to medical establishments. The fear of being ostracized from family and society and of losing the respect of friends and loved ones makes women refuse treatment for as long as possible and conceal their disease. However, the experts fail to acknowledge the importance of analyzing female specific problems like interpersonal/domestic violence which women with substance use problems face.

In addition, the experts fail to mention that even those women who try to overcome their fear of being stigmatized and enter the treatment center are not only facing problems related with stigma and discrimination from the part of male counterparts, but also dealing with structural problems related with the absence of female-oriented treatment and untrained and inexperienced staff.

One of the most important findings of the present chapter is that the opinions of most of the interviewed experts in my study appeared to be gendered, revealing an inclination towards gender stereotyping and lacking the gender awareness when analyzing female drug use problems.

In addition, it must be noted that gender sensitivity/insensitivity of the experts, whether male or female, did not greatly differ from each other. Female experts, both young and old, were similar to male experts in that they were mostly stereotyped when talking about women respondents. Moreover, in some cases women experts were even more critical than men. However, interestingly, the degree of sensitivity proved to be related to the place of work. The interviews with experts showed that individuals working in the non-governmental sector are more aware of specific problems of female drug users and are more tolerant when talking about them than experts from other institutions. The needs of female drug users' are mostly highlighted by representatives of NGOs (particularly from those organizations that are cooperating with the Georgian Harm Reduction Network), especially the disregard for women's needs during treatment, and the preventing factor of stigma in the process of working with and treatment of women. I think that this difference between the representatives of NGOs and those of state/private medical institutions may be conditioned by the fact that individuals at state/private medical institutions examine the problem more according to the biological and medical model and analyze the drug dependence problems of both sexes through the lenses of biological determinism. While representatives of the non-governmental sector, most of who are cooperating with the Harm Reduction Network, are guided by the harm reduction principle when addressing addiction problems and are more in favor of the biosocial model. However, one of the most significant factors determining the fact that non-governmental sector workers are more women-oriented and sensitive may be related to the policy of international donors. Recently, such big donors as the UN and EU have announced a number of research grant competitions to collect information on female drug users in the Eurasia region and to implement advocacy issues. Many NGOs were engaged in the said projects and the consciousness of their representatives and the degree of awareness has consequently risen. However, it must be noted that, on the whole, the attitude of the majority of experts towards this issue remains gender biased.

Chapter 5

Men and Women With Drug Use Problems

Introduction

According to recent data, women constitute approximately 20 percent of all individuals with substance use problems in post-Soviet countries.³⁹⁴ Of 40,000 officially registered individuals with drug dependence in Georgia (systematic users of hard and/or injective drugs) about 10 percent are women,³⁹⁵ however most studies in Georgia still focus their attention and resources specifically on what is referred to as ‘the majority’ of the drug using population – which means studying only males or adding women into male-biased paradigms. Anderson (2001) describes that up to the early 1980s, studies on addiction tended to be focused only on men and did not factor in the needs of female drug users. Since then, the trend has changed gradually and gender-related and women-oriented issues have gained the spotlight in the studies on drug addiction. However, in Georgia and in the Eurasia Region the specificities and needs of women are still disregarded and the majority of services and studies are still focused on male drug users. A clear example of this is the fact that Eastern European and Central Asian countries, even those that provide opioid substitution treatment with methadone or buprenorphine, do not have clinical practice guidelines on how to manage drug use when women are pregnant, during birth or in the years of early development.³⁹⁶ The study ‘No Woman Left Behind? The Limits of Reproductive Health and Rights for Women Who Use Drugs in Russia’ states that in Central Asia the majority of women in substitution therapy cannot receive medical advice even regarding the effect of the opioid substitution therapy on their pregnancy and breastfeeding.³⁹⁷ The study shows that Ukrainian general practitioners and prenatal care providers have no information on how opioid substitution therapy affects pregnant women and what are the benefits or detriments of such therapy. Consequently, when female substance users visit prenatal services, they are not referred to specialists

³⁹⁴Otiashvili, D., Kirtadze, I., O’Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012). “Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers.” *International Journal of Drug Policy*, Available <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>, Accessed: 19.06.14.

³⁹⁵Sirbiladze, T. (2010). “*Estimating the Prevalence of Injection Drug Use in Georgia: Consensus Report*.” Tbilisi: Bemoni Public Union.

³⁹⁶Tolson, R and Rychkova (2012). “No Woman Left Behind? The Limits of Reproductive Health and Rights for Women Who Use Drugs in Russia.” Available at: http://www.centerwomenpolicy.org/programs/health/statepolicy/documents/REPRO_NoWomanLeftBehind_RebeccaTolsonandOlgaRychkova_000.pdf, Accessed: 19.06.14.

³⁹⁷ Ibid.

for advice and treatment. Furthermore, the facilities providing ‘cold turkey’ residential programs in Central Asia lack the necessary equipment to satisfy women’s needs. Another major problem for substance using mothers in these countries is the fact that state-owned in-patient drug treatment institutions have no childcare facilities and therefore women cannot take their children with them. There are also no programs for couples, so women have to make a choice between treatment and family.³⁹⁸

According to the results of the only available research on women who have substance use problems in Georgia, 80 percent of the females have never been tested for HIV, 80 percent of drug-dependent women have experienced domestic violence and 64 percent of them are unaware if there are any harm reduction services in their neighborhood.³⁹⁹ Furthermore, a study conducted in Georgia, Azerbaijan, Ukraine, Russia, and Kyrgyzstan shows that there are many factors that prevent women from starting to treat their substance use problems or to turn to services that specialize in drug dependence.⁴⁰⁰

In Russia, for instance, substance users who want to enroll in the government-funded treatment program, have to register on state registers.⁴⁰¹ This creates yet another barrier for women, because the Family Code of Russia stipulates deprivation of parental rights if a mother is diagnosed with substance dependence disorder. If the name of a substance using mother appears on the register it may prevent her children from enjoying welfare protection services. The results of the survey in Kyrgyzstan indicate that 9 percent of school-age children of substance using women did not attend school, because schools would not admit children due to their mothers’ addiction.⁴⁰²

The possibility that women’s confidentiality may be compromised, that they may or may not be referred to sexual and reproductive health services, and that such services are predominantly male-focused are among the above factors.⁴⁰³ There are few studies examining the incidence and prevalence of substance-using women in Georgia. No empirical study has been conducted to examine in what social setting, how or why women use substances. The lack of systematic data on women with

³⁹⁸ Ibid.

³⁹⁹Otiashvili,D., Kirtadze, I., O’Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012). “Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers.” *International Journal of Drug Policy*, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

⁴⁰⁰ Ibid.

⁴⁰¹Tolson, R and Rychkova (2012). "No Woman Left Behind? The Limits of Reproductive Health and Rights for Women Who Use Drugs in Russia." Available at: http://www.centerwomenpolicy.org/programs/health/statepolicy/documents/REPRO_NoWomanLeftBehind_RebeccaTolsonandOlgaRychkova_000.pdf, Accessed: 19.06.14.

⁴⁰² Ibid.

⁴⁰³ Ibid.

substance use problems results in little awareness about this part of society and this lack of knowledge makes it hard to come up with strategies that will engage women in treatment.⁴⁰⁴

Therefore, I think that the data analyzed in this particular chapter constitute an important contribution in terms of shedding more light on female drug use experience and problems in Georgia and comparing it with those of men. The aim of this chapter is to show the differences between men and women with substance use problems and to demonstrate how important it is to look at women's problems from the gender perspective. Understanding similarities and differences across a variety of attitudes of men and women starting drug use, exploring differences of their drug use and the kinds of problems and barriers they encounter may improve the development of gender-specific programming.

Gender differences in the motivation and first use of illegal drugs

Most adolescents start using substances when they are in a transitional period.⁴⁰⁵ At this time they grow, mature and become more independent.⁴⁰⁶ In addition, adolescents prefer to take their cue from their peers rather than from their family, and become less obedient to parents. Viner and Taylor (2007) have shown that adolescents who use substances may continue this practice when they become adults, and may encounter problems of dependence.⁴⁰⁷ There are different reasons for substance use, and many young people may think that experimenting with tobacco, alcohol and drugs is a normal way of life for an adolescent.

However, most of the recent studies acknowledge the importance of analyzing drug use experimentation and its reasons through the gender lens and highlight the specific problems and complications females with substance use face. It is widely observed that men and women differ in their reasons and motivations for drug use.

The male respondents interviewed in my study listed different reasons for their systematic use of drugs. In the first place, they emphasize the desire to feel the pleasure they experienced when they first tasted drugs, then comes their circle of friends, the environment in which everyone uses drugs systematically, and the unique ability of drugs to enable a person to feel more confident and omnipotent.

⁴⁰⁴ Ibid.

⁴⁰⁵ Gilvarry, E. (2000). "Substance abuse in young people," *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 41, pp.55-80.

⁴⁰⁶ Ibid.

⁴⁰⁷ Viner, R.M., and Taylor, B. (2007) "Adult outcomes of binge drinking in adolescence: Findings from a UK national birth cohort," *Journal of Epidemiology and Community Health*, 61, pp. 902-907.

'There are many people who want to establish themselves in the circle of guys, in their neighborhood. When their friends inject drugs, they don't want to lag behind.' (R1, male, 25 years old, Gori)

'To get the pleasure they got the first time they took drugs. This lasts for a certain period, and then you only take drugs to avoid feeling bad.' (R1, male, 28 years old, Tbilisi)

'When you are not under the influence of drugs, you think you are not doing well, you don't have strength, and you are incapable of doing anything.' (R6, male, 38 years old, Gori)

It should be noted that the male respondents, particularly in Zugdidi and Gori, name the possibility to escape from social problems as a cause of systematic use of drugs. The respondents also talk about such problems as unemployment, financial hardship, and the related feeling of inferiority and incapability.

'We, young people, have a lot of reasons today. First of all, unemployment. Those who have not studied and haven't graduated from college or university. It's even difficult for people with diplomas. They also sit at home and are unemployed. And when you hang around in the street, you either have to drink or take drugs or steal something or do something like that. Why else do you hang around in the street then?' (R8, male, 28 years old, Zugdidi)

Most of the male respondents interviewed in the three cities (Tbilisi, Zugdidi and Gori) say that they first tasted drugs at the age of 14-15, confirming the opinion expressed by the experts and other scholars. Before sharing their drug experience, most of the respondents started talking about their life before they became drug users. Considering that almost the majority of the male respondents started using drugs (mainly intravenous drugs) actively just before or after graduating from school, when they were school students, they describe their life before starting to use drugs as 'an ordinary life' which included studying, sports, parents, and, in some cases, a marriage and a job. Interestingly, when remembering their life before they developed a strong dependence on drugs, the respondents themselves mentioned the (possible) factors that stimulated them to start using drugs, such as the war that started in the 1990s,⁴⁰⁸ the criminal mentality prevalent in the 1990s, and the positive attitude of society to drugs and drug users (see details regarding the drug situation in Georgia in the 90s in Chapter 3).

⁴⁰⁸ The respondents talk about the War of Abkhazia, waged in 1992-1993 chiefly between Georgian government forces on one side and the [Abkhaz](http://en.wikipedia.org/wiki/Abkhaz) separatist forces supporting [Abkhazia](http://en.wikipedia.org/wiki/Abkhazia)'s independence from Georgia, Russian armed forces, and North Caucasian hired fighters on the other. See more detailed information at: [http://en.wikipedia.org/wiki/War_in_Abkhazia_\(1992%E2%80%931993\)](http://en.wikipedia.org/wiki/War_in_Abkhazia_(1992%E2%80%931993))

'Our generation had an interest, and those who took drugs at that time were considered as cool guys; they dressed well and drove good cars...' (R4, male, 29 years old, Tbilisi)

Some male respondents also emphasize such specific factors as the stress inflicted at the formation age (caused by the death of a loved one), development of dependence on alcohol and/or what is referred to as 'grass' (marijuana), and the influence of the circle of acquaintances who used drugs.

'I studied at school; then I graduated from school and studied at an institute; I studied there till the middle of the year and then I quit. It was, so to say, a disordered life – in my childhood, my life was all about war and birja⁴⁰⁹. I had parents, brothers and sisters by my side; I was quite a clever child.' (R2, male, 44 years old, Gori)

'I was self-conscious about communicating with strangers; in fact, I grew up in the street, in the neighborhood, as most of us did. When I was 11 years old, my father died; I worried a lot about this and started smoking cigarettes. When I was 13, my friend and I had a fight at school; my friend's brother accompanied us and stood beside me during the fight. He was killed by a friend of mine, about half a meter away from me. I had a terrible depression and neurosis, and my mother took me to the village.' (R1, 28 years old, male, Tbilisi)

As it turns out, the majority of the male respondents with drug use problems started smoking marijuana at an early age, when they were 12 or 13, and then got acquainted with more serious and stronger narcotic substances. All the male respondents without exception confirm that they first tasted drugs willingly, though their circle of friends had a considerable influence. There were a lot of individuals using drugs in the respondents' circle of friends, and being in such an environment created an intense desire and interest in drugs in each of them. Drugs were often offered by older friends who also ensured the availability of drugs.

'I first tasted heroin willingly.' (R1, male, 29 years old, Zugdidi)

'No one put pressure on me. The other day, we, old drug addicts, were remembering a joke in which a man says: "Show me the place where they inject drugs by force."' (R4, male, 29 years old, Tbilisi)

Almost all the respondents noted that their lives deteriorated because of drug dependence, their health was damaged, they spent large amounts of money, and their reputation was tarnished. Several of those interviewed also emphasized that they feel better only when they are under narcotic intoxication and

⁴⁰⁹ A term used in Georgia to denote a place in a neighborhood where people, especially boys and young men, loiter and hang around.

then only for a few hours; they say that, for this reason, a drug-dependent person's thoughts are mainly focused on obtaining drugs, which, in its turn, causes a reappraisal of values in them; taking the needs of family members into consideration, helping them, and having relationships with them become of secondary importance, and the satisfaction of their own needs, even by illegal means (taking by force, theft, etc.), becomes the only important thing for them.

'Everything becomes black and white; the values you have slowly disappear, and when you wake up in the morning, you only think about where and with whom to inject drugs. Until you do that, you steal and you rob. Obsessed with your aim, you are no longer interested in your parents, wife, and children. And when you inject drugs, you no longer want anything else; you are left alone with yourself.' (R6, male, 33 years old, Tbilisi)

'It was normal before I started using drugs. After that, my health was ruined. There was a time when my financial condition was normal; I mainly spent money on this. This is reality - I ruined myself financially, and I entered a period of ruin. When I sobered up, I was already broke. It was in the early period, before I quit it.' (R2, male, 44 years old, Zugdidi)

The list of narcotic substances that the male respondents used for the first time (and were dependent on) includes such drugs as marijuana, Subotex, Tramal, 'Jeffy', Heroin, and Morphine. All the male respondents name personal interest and the environment (circle of friends who used drugs) as the main reason for tasting drugs.

When I asked the respondents to name the major factor that triggered their interest in drugs, almost all of them cited the situation in 1990s, a positive, inherently wrong attitude towards drug users, reverence to thieves traditions and the influence of their friends as principle reasons for drug use.

'All of us lived during 90s and it was considered that a 'good guy' had to taste drugs. Everybody was on drugs; at school, in the neighborhood, everywhere, and this was considered cool behavior and good style.' (R7, male, 37 years old, Tbilisi)

'Maybe, if it had not been for the 90s I wouldn't have been in such trouble.' (R6, male, 35 years old, Zugdidi)

'Definitely, the major factors were environment, friends and the society I lived in. You may find it hard to imagine, but it really was uncool not to inject or taste drugs and not to help someone to obtain them. There was a different mentality and situation, but I grew up in such mentality and situation and consequently I followed suit.' (R6, male, 38 years old, Gori)

To sum up, the major reasons for a male drug user to taste drugs during adolescence are the situations, social relations, or social structures in which the individual was located. Accordingly, we can discuss the examples given by them from the perspective of social theory, specifically from the perspective of social learning theory. According to social learning theory, drug behaviour can be learned by observing other people's behaviour.⁴¹⁰ According to Goode (1989), individuals learn crime and deviance – when they interact with others closely, face to face, or with people close to them.⁴¹¹ A person becomes deviant or criminal if the definitions he/she comes in contact with favor the violation of the law more than non-violation.⁴¹² According to Social Learning Theory, a person's behavior depends on the rewards and punishment, or reinforcement he/she receives.⁴¹³ Individuals continue certain actions based on the past and present rewards and punishments for such actions. While interacting with certain groups of people or social circles, individuals learn what behavior is defined as bad and what as good. When individuals are in a group, they are rewarded or punished, are exposed to behavioral models and this happens in different ways in different groups.⁴¹⁴

Therefore, if we consider that in the 90s the use of drugs was a model behaviour and was even encouraged in adolescents (for detailed information see Chapter 3), we get a picture where a circle of friends, which in its own right has great influence on the behavior of adolescents, as well as the trends and situation within the country, played a significant role in the formation of the wish of or reason for the male respondents to taste drugs. Many individuals wanted to become a member of the society where drug use was considered a good form and drug users were role models. Most of the male respondents admit that they wanted to look cool and therefore had to share those views and engage in the actions that were characteristic of the members of such social circles.

'If you did not want to lose your friends, be an outcast and often an object of ridicule, you had to inject. Anyway, this is the way I see the situation of the time. I might be mistaken and this was the perception at that time, but generally you were either rejected and many guys were rejected and went the other way. Now I realize that they went the right way, but at the time they were not happy, because they were alone and could not be friends with us. But, I don't know, maybe that was all to the good, and if I had done the same I would be in a better situation, but at the time I thought differently. My friends were my priority and still are.' (R6, male, 35 years old, Zugdidi)

⁴¹⁰ Bandura, A. (1977). "Social Learning Theory." General Learning Press.

⁴¹¹ Goode, E. (1989). "Drugs in American Society." New York: McGraw-Hill Publishing.

⁴¹² Ibid.

⁴¹³ Ibid.

⁴¹⁴ Ibid.

'He who used drugs was a role model and a cool guy, drove a good car, was popular among girls, was respected. So, you began to want to be like him. At the time you think your actions are right. You also think that nothing bad will happen to you; when injecting you feel that you are the best. If you don't inject, you realize that you no longer belong to their group, you are different, a lesser person. Such ideas and feelings are the main drivers that make you inject again and feel as part of their group.' (R5, male, 45 years old, Tbilisi)

For example the sub-cultural theory holds that if individuals are part of a particular social group which favors drug use, they are encouraged to use drugs, whereas if individuals are part of a group which does not favor drug use, they are actively discouraged and even punished.⁴¹⁵ This theory clearly explains the reasons why men choose to taste drugs in order to become members of their favourite group.

In the case of women, the situation is different, although at first glance it does not seem so. Their age of tasting drugs for the first time varies from 14 to 35 years. The list of narcotic substances that they tasted for the first time includes different drugs: Marijuana, Subotex, Ecstasy, 'Black',⁴¹⁶ Heroin, etc. Like the male respondents, the majority of the female respondents also note that the reason for using drugs for the first time was interest. And only a few of them rule out at the beginning of the interview being coerced and pressured to taste drugs for the first time.

'I was always terribly interested in why they were so dependent and why they needed to do this; I was very interested, and, as I was a bit light-headed, I thought it wouldn't kill me if I tasted it once.' (R2, female, 34 years old, Zugdidi)

'I first tasted drugs after the breakup of my family, two years after that. My husband and I broke up, and I was left alone with a child. I was literally bitter, and I was capable of doing anything at that time.' (R4, female, 30 years old, Zugdidi)

As the female respondents note, access to drugs was ensured by the circle of their friends and acquaintances (whose members consumed drugs actively). They not only tasted drugs for the first time, but also obtained them systematically through the circle of friends. It should be noted that a large number of the female respondents interviewed in Tbilisi first tasted drugs abroad, specifically, in Kiev, Prague and Berlin. The respondents recall that at an early age they were abroad together with their friends and had access to narcotic substances; it was there that they started consuming narcotic

⁴¹⁵ Goode, E. (1989). *"Drugs in American Society."* New York: McGraw-Hill Publishing.

⁴¹⁶ A street name for poppy.

substances, specifically, Ecstasy. However, several women emphasize that they did not have any information about Ecstasy and similar drugs and when they first tasted it, they didn't know it was a narcotic substance.

'We, a group of ten friends, were in Prague and tasted Ecstasy there. We were 16 or 17 years old, and we liked it very much, but we didn't know it was a narcotic substance. We were so young and liked it so much that we brought it back to Batumi in packages. There were festivals in Batumi at that time called Subtropics, and over those three months, I took it at noon, in the afternoon, and in the evening. I had not heard that it was a narcotic substance. It was not known in Georgia then; it was introduced here later.' (R3, female, 27 years old, Tbilisi)

'I had a vacation for some time, and my life got messed up at the time of the vacation. I first tasted marijuana; it was in Kiev. Then I tasted heroin. Everyone was high and I was very interested what it was. I turned 19 there. At that moment, I liked it. I kind of wanted it and I took it for this reason. Afterwards, I took it because of pain.' (R9, female, 27 years old, Tbilisi)

Almost all the females with drug use problems who were interviewed say that they had an easygoing and carefree life before they developed drug dependence. The female respondents interviewed in Tbilisi and Zugdidi, in particular, note that when they were children and teenagers, their parents did their best to ensure that they had a carefree life. The number of female respondents who say that they were not very happy and satisfied with their lives before starting to use drugs is the highest in Gori. Some of the female respondents got married quite young and their lives were burdened with family problems from an early age; some of them had to live under harsh conditions due to financial hardship even without that. It is also interesting that in Zugdidi marijuana was as easily accessible for women as it was for men (almost all the women interviewed in Zugdidi had tasted marijuana at least once before they tasted more serious drugs, despite the fact that we are talking about a province and the lives of women living in a province two or three decades ago). The majority of the female respondents received secondary education at school, then they continued studying at university, and got a job; some of them got married (especially those in the provinces). The majority of the female respondents tasted serious drugs (Ecstasy, Subutex, Heroin) after finishing school and started to use them actively, willingly, and out of interest (except several cases of forced use).

'Before that, I studied in the Medical Institute. I met my husband there. He had escaped from prison. I didn't know he was a drug addict. I took a year off in the first year, and he didn't let me go back to the institute. I grew up in a boarding house. I was happier before the marriage. I had passed the exams

myself and was studying in the institute. After I got married, my situation changed.' (R1, female, 26 years old, Gori)

'I was really both happy and satisfied before I started using drugs. I had a carefree childhood; my parents fulfilled all my wishes and requests and spoiled me very much. I grew up very freely, I had nothing to worry about.' (R4, female, 30 years old, Zugdidi)

'It was different; I went to university, studied, and had a quiet life. I was at home, with members of my family; I went to school, then to university.' (R5, female, 32 years old Tbilisi)

The female respondents note that drug dependence changed their lives for the worse, which is manifested in the deterioration of their physical and psychological health, poverty (starvation caused by poverty), and rejection and ostracism by their loved ones. In Zugdidi and Gori, the female respondents complain of pains which they relieve by psychotropic medicines and home-made narcotic substances; they also complain of depression and neurosis. They note that they are aggressive and secretive and avoid communicating with other people. Due to drug use, three of the female respondents interviewed in Tbilisi were arrested; two of them served their sentences, while, in the case of one of them, a suspended sentence was passed.

'My husband started injecting. When he ran out of drugs and they became hard to obtain, we sold everything we had to sell. I even begged in the street. Then we switched to cheaper drugs. I have also injected "Jeffy" two or three times. "Margantsovka"⁴¹⁷ was cheap; it was a matter of GEL 12 (7 USD) and it was enough for me for a couple of days.' (R5, female, 33 years old, Zugdidi)

'[It changed] for the worse; it showed in people's attitudes. Then I was arrested, and after I was released, I developed a complex. People seemed to have changed, and everyone already looked at me with suspicion.' (R3, female, 27 years old, Tbilisi)

At first glance, the reasons and experiences shared by female respondents are very similar to those of males. Therefore, it may seem that there is no difference between male and females in terms of the wish and reasons for drug use, because women, like men, cite their own interest and friends as the main reasons for tasting drugs. However, when I asked women respondents about other women and asked them to share their views on the reasons for drug use among Georgian women, or what it meant to be drug-dependent, and the similarity in terms of the problems that men and women users face, the conversation with almost all of the respondents took a different turn. As opposed to men who talked

⁴¹⁷A colloquial term for potassium permanganate.

about the situation in 90s and their friends' influence, the female respondents cited family, spouses, situations related to personal psychological problems in the family, and noted that sometimes drugs are the only way for a woman to escape from reality.

'Yes, at first you may use drugs because of interest and pleasure, but once you taste it and realize that this substance makes you forget all problems, escape from the harsh reality you live in, then you turn to them again and the only time you feel happy is the time when you are high.' (R4, female, 30 years old, Zugdidi)

'When you inject drugs, you think everything is going to be all right. When you inject drugs, you think you are the happiest and the best, and, later, when you sober up, you hate yourself and want to inject again.' (R1, female, 26 years old, Gori)

'I get rid of all the problems and I'm delighted. I'm relaxed. I don't remember anything - I forget the problems and no longer think about the future.' (R4, female, 30 years old, Gori)

'Depressed state, a hard psychological state caused by family conditions... caused by a lot of things.' (R1, female, 27 years old, Zugdidi)

'First of all, it's about avoiding and escaping from family problems ...' (R2, female, 34 years old, Zugdidi)

It should also be noted that the female respondents mention psychological tension and depression when talking about drug addiction. Quite a considerable number of the women, unlike the men, acknowledge that they use psychotropic substances in order to cure depression [none of the men mentioned using psychotropic substances]. It is noteworthy that psychotropic substances are actively consumed by the female respondents who were interviewed in Gori. For example, seven female respondents interviewed in Gori acknowledge that they actively consume psychotropic substances in order to be calm, but the amounts consumed by the respondents markedly exceed the amount that is enough for a person to be calm. The female respondents interviewed in Gori had mainly been users of opiates and then, due to a number of reasons (one of the main reasons being limited access to opioids on the Georgian market, see details in Chapter 3), switched to psychotropic substances.

During the interviews with this group of respondents (women from Gori), it was visible that they did not consider medicines of this group as narcotic substances. For example, when talking about opioids and narcotic substances of other groups, the women used such terms and words as 'pleasure,' 'physical dependence,' 'being high on drugs,' and 'cold turkey,' and when they talked about the narcotic

substances of the psychotropic group, they only said they needed these medications to overcome a depressed state.

'Depression is added to all this, and in order not to get hysterical or to let the children see my emotions, I use these substances more often, trying to hold myself back in this way.' (R2, female, 29 years old, Gori)

Two major factors are worth noting when talking with women. The first factor is that women find it more difficult to share personal experiences than men, while men talked about the reasons of their tasting drugs openly, although disappointedly, provided details about the setting and conditions where they tasted drugs for the first time. Women tried not to dwell on such issues and their account about their friends' influence and interest as the main cause for tasting drugs was short and superficial. But when the conversation shifted to the problems of other women and their experiences and problems, female respondents found it easier to talk and the conversation took a radically different turn. It is worth noting that at first most of the women respondents attributed their own suffering and experience to others, that is, they started the conversation by talking about the experiences of their acquaintances or friends, however they continued to talk in first person. Another noteworthy fact is that unlike men, women talk about personal problems, heavy state of mind related to the problems in the family, and personal relations. In this case it should be underscored that most of the women claim they can escape from and forget reality through drugs, and the factors leading to their first tasting of drugs are no longer important. It is true that most of them tasted drugs for pleasure, and it was later when they realized that drugs were the only way for them to forget the reality, family problems and disagreements that troubled them.

As Goode describes, several psychological theories of drug use argue that there is something wrong in the emotional or psychic life of certain individuals that makes drugs attractive to them.⁴¹⁸ These individuals with emotional and/or psychic problems start to use drugs as an escape from reality; as a means of avoiding life's problems and retreating into euphoric bliss and drugged-out indifference.⁴¹⁹ If we consider the experiences of the women respondents from this point of view, we will see that their heavy states of mind makes them use drugs, and it is heavy because of the family problems and conflicts. It is clear that the problems cannot be solved by turning to drugs, because in this way the

⁴¹⁸Goode, E. (1989). *"Drugs in American Society."* New York: McGraw-Hill Publishing.

⁴¹⁹Ibid.

problems never get solved, only covered up, and meanwhile, drug use itself generates a host of other more serious problems. But the fact is that in the case of these women, drug abuse appears to be a defense mechanism, and a means of erasing feelings of inferiority and helplessness.

Therefore, it comes out that the main factor for the women tasting drugs (except for six respondents) is interest, and that their circles of friends provide drugs and encouragement. However, the reason for repeated and systematic use is the ability to escape from reality. This is especially true for the women from the regions (Zugdidi and Gori). They acknowledge that severe psychological terror in the family, continuous insults from their husbands, lack of love and peace, absence of support and stability are so depressing that they choose drugs as the preferred means of escape.

'Never-ending insult, groundless humiliation, just because I am a woman. I wonder what would he have done if I were not a woman ?!'(R4, female, 30 years old, Gori)

'Shouting, dissatisfaction, venting on me all that is bad... It is very difficult when you do not have anybody to turn to for support. The husband is supposed to be the one to support you in the first place, and instead, you are afraid of him; he is the one who hurts and humiliates you.' (R6, female, 36 years old, Zugdidi)

'When everything is restricted for you, groundless jealousy: Where did you go? What did you do? Who did you talk to... ? It's very hard and there is no way out... ' (R4, female, 30 years old, Tbilisi)

By inequality and subordination to men in the family, most of the women mean the oppressed state that they want to escape. As other means of escape are unknown or inaccessible for them, they resort to an illusory means of solving the problem, which enables them to forget problems only for a certain period of time, but later become the cause of more serious problems. The unequal and subordinated position, often manifested in different forms of violence, have a detrimental influence on women's mind and health.⁴²⁰

The problem of violence against women is a serious challenge for Georgian society. Many studies show that in some countries physical violence or brutality committed by men against their wives was an accepted fact as a 'punitive correction' in cases where women did not comply with social

⁴²⁰ Sen, G., Östlin, P. and George, A. (2007). "Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it?" Final Report to the WHO Commission on Social Determinants of Health. Available at: http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf, Accessed: 16.01.14.

mandates.⁴²¹ The most recent survey conducted in Georgia covering domestic violence issues is the National Research on Domestic Violence against Women in Georgia, which was carried out in 2010 and aimed to estimate rates of domestic violence against women in the whole country.⁴²² According to the above-mentioned study, 35.9 percent of women disclosed having experienced controlling behavior from an intimate partner since the age of 15.⁴²³ While no total rate for economic violence was provided (only rates for individual acts constituting economic violence), 4.7 percent of women admitted to having earnings forcefully taken away by their intimate partner.⁴²⁴ This study clearly demonstrates that ‘among women who have ever been married, every eleventh is a victim of physical abuse and 34.7 percent has had injuries several times.’⁴²⁵ Most of these women are between the ages of 45-49.

Most often they suffer injuries such as scratches, abrasions, bruises (84.4 percent) and internal injuries (29.1 percent). 18.8 percent of women have experienced brain concussion due to the violence of their husband/partner, 15.3 percent of women who have been victims of their husband’s/partner’s physical or sexual violence have needed medical assistance at least once. Among them, 18.2 percent of women have received medical assistance. 33.3 percent of women report spending from two to 30 days at the hospital.⁴²⁶

Family problems, an oppressed or humiliated state, especially constant control of women’s actions by their husbands, is clearly manifested in the interviews and especially in the case of those six women who named their spouses / partners as the sole reasons for their use of drugs.

When talking about the reasons for tasting drugs for the first time and describing the situation, the afore-mentioned six female respondents told me in detail about their cohabitation with drug-abusing husbands and intimated indirectly, if not directly, that it was this cohabitation that caused them to taste drugs. As a result of cohabitation with a man who was drug-dependent, some of these women

⁴²¹ Rico, N. (1997). “Gender-based Violence: A Human rights Issue.” Available at: <http://www.eclac.org/publicaciones/xml/3/4743/lcl957i.pdf>, Accessed: 20.01.14.

⁴²² Chitashvili, M., Javakhishvili, N., Arutiunov, L., Tsuladze, L., Chachanidze, S. (2010). “National Research on Domestic Violence against Women in Georgia.” Available at: <http://www.genderbasedviolence.ge/conimages/annual-eng.pdf>, Accessed: 5 July 2012.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Ibid.

⁴²⁶ Chitashvili, M., Javakhishvili, N., Arutiunov, L., Tsuladze, L., Chachanidze, S. (2010), “National Research on Domestic Violence against Women in Georgia.” Available at: <http://www.genderbasedviolence.ge/conimages/annual-eng.pdf>, Accessed: 5 July 2012.

developed a desire and interest to taste a narcotic substance, while, in some cases, their already existing desire and interest intensified. Two ladies directly stated that they had been pressured and coerced by their husbands to taste drugs.

'I was 22 when I got married. My husband took me by force, made me stay at his home, and injected me forcibly with a drug. He, in fact, injected me by force. I had a fever after being injected. He told me he was going to make me a drug addict, so that I would not be able to leave him. My husband was a serious drug addict.' (R7, female, 50 years old, Gori)

'I was 18 years old. My husband took drugs. He made me smoke marijuana. I didn't inject drugs. When I had the second child, it was unbearable for me to watch him and his friends coming in crowds and injecting drugs. And it was a time when they all carried guns. When he was under the influence of drugs, he twice fired his gun accidentally. I injected at the age of 20. I told him I would divorce him unless he injected me.' (R4, female, 30 years old, Tbilisi)

The experience shared by these respondents where they started using drugs at the initiative and in some cases by the force of their male partners, proves the idea argued by Georgian experts (see Chapter 4) that men are main initiators in the case of women drug use. Even those women who did not directly blame male partners for their drug dependence, and only noted that systematic use enabled them to forget family problems, recalled cases where their acquaintances and neighbors started using drugs because of men. Some women even say that they have heard of many cases when a man injected his wife or girlfriend with drugs by force. It was notable that for women it was easier to talk about others' experiences.

'I know of many families in which the husband injected the wife with drugs while she was asleep, because the wife had her own business and if he managed to involve her, it would be easier for her to obtain drugs.' (R3, female, 42 years old, Zugdidi)

'Some women have drug-abusing husbands who inject them so that the wives will no longer quarrel with them. Some women inject themselves in defiance of their drug-abusing husbands.' (R5, female, 39 years old, Gori)

Only a few of the men agreed that the experience shared by women coincides with the ideas held by the experts. Some of the male respondents even got angry and aggressive on hearing the afore-mentioned opinion, expressing concern that this opinion had been established in the Georgian reality.

'What nonsense, men have nothing to do with that. Show me a man who forces anybody, especially a woman, to do anything. Those women wanted to inject and did so, then they have to blame somebody for their mistake. It is difficult to blame yourself.' (R2, male, 31 years old, Tbilisi)

At the same time, other male respondents argued the opposite and even said that men got their female partners to start using drugs with very egoistic aims. They also recalled cases that reinforced the accuracy of the afore-mentioned opinion.

'For example, I know of a case when a husband injected his wife with a narcotic substance; she is a friend of our family. When you know what it is and still inject it into a person, you practically doom her. But you know what it's like? A friend of mine told me that it would be good if his wife were also a drunkard, because they would drink together. It's more comfortable. They do it for their own comfort.' (R4, male, 29 years old, Tbilisi)

The fact that men often make women start using drugs for egoistic reasons is clearly visible in the report 'Women who inject drugs: A review of their risks, experiences and needs' which describes a couple leading their daily life and their drug use, particularly how they divide tasks in order to get hold of drugs, food and other needed supplies.⁴²⁷ The report also examines the effect that such a relationship has on substance-dependent couples.⁴²⁸ According to the report, female injectors often engage in sex work to provide for their partner and/or family as part of the gendered division of labor. Further, some females with substance use problems report that the reason they have sex relationships with their partner is connected with having shelter, food, drugs and/or protection. Such relationships may make the women vulnerable because they depend on these men and they cannot require from their partners to engage in safe sex or practice injection safely.⁴²⁹ As Dawson et al. (2007) argue, some women continue using alcohol and illicit drugs to have an activity in common with their partners or to maintain the relationships.⁴³⁰ The man often supplies drugs, and the woman becomes dependent on him for drugs. Some of the respondents admitted to have used drugs in order to have an activity in common with their partners or to save the relationship.

⁴²⁷ Roberts, A., Mathers, B., Degenhardt, L. "Women who inject drugs: A review of their risks, experiences and needs." Available at: http://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf, Accessed: 17.01.14.

⁴²⁸ Ibid.

⁴²⁹ Ibid.

⁴³⁰ Dawson D., Grant B., Chou S., Stinson F. (2007). "The impact of partner alcohol problems on women's physical and mental health," *Journal of Studies on Alcohol and Drugs*, 68(1), pp. 66–75.

'I was of secondary importance for him. I could not stand watching him being with his drugs and me by myself. So I asked him to inject and he clearly did not refuse. I thought I could keep the family this way.' (R9, female, 27 years old, Tbilisi)

Overall, it is obvious from the view of the men and women respondents (except for those who dismissed the idea that men were the initiators of women's drug abuse) that a man's desire to offer drugs to his partner is connected with the willingness to increase his power and control over her. The examples provided by the respondents clearly demonstrate cases where women were forced to use drugs for the purpose of exercising direct control over and subordinating them. In other cases women tried to save their relationships, as they felt unimportant compared to the drugs. There are cases where women try to have common activities and interests in order not to lose their partners. The stories shared by the respondents also reveal oppressed women who are trying to escape from reality through drugs. Their reality includes their subordinated, unequal, oppressed position. Drugs offer only illusory escape and, as drug users, women become victims of even more oppression, discrimination, and stigma.

The social stigma against individuals with drug use problems

As Crocker et al (1998) defined: 'A person who is stigmatized is a person whose social identity or membership in some social category, calls into questions his or her full humanity; the person is devalued, spoiled, or flawed in the eyes of others.'⁴³¹

According to Goffman (1963), stigma has a property that turns a complete person of good standing into a blemished and devalued one.⁴³² Characteristics leading to stigma may be clearly seen (e.g. cleft palate) or hidden (e.g. sexual orientation). Generally, they are linked to how a person looks, behaves or to which group he/she belongs. Goffman (1963) suggested that individuals who have hidden stigmas find themselves in a social atmosphere comprised of two levels, the discredited and the discreditable. In the discreditable atmosphere, the attributes of an individual that may lead to his/her stigmatization are hidden and may successfully remain that way; however, there is a chance that the individual's stigma may become known, either knowingly by that individual, or due to some unforeseen factors. The stigma which the individuals with drug use encounter is the discreditable stigma - the individual's

⁴³¹ Crocker J, Major B, Steele C. (1998). "Social stigma." Handbook of Social Psychology, ed. S Fiske, D Gilbert, G Lindzey, vol. 2, pp. 504–53. Boston, MA: McGraw-Hill.

⁴³² Goffman, E. (1963). "Stigma: Notes on the Management of a Spoiled Identity." Englewood Cliffs: Prentice-Hall, Inc, p.3.

stigmatized status which is not immediately evident and may be successfully concealed.⁴³³ But if it is revealed, drug users become victims of strong stigma, especially because they are viewed as people who can control their health condition and therefore are more likely to be blamed.⁴³⁴ According to Corrigan (2000), society responds to substance use problems depending on the severity of stigma. Society may react in different ways, for instance they may express anger, avoid people with substance use problems, punish them or force them to seek treatment. The stigma also influences the way substance abusers view themselves.⁴³⁵

Various studies also suggest that people who abuse drugs resort to different strategies for fighting and coping with stigma. Hiding their dependence on drugs is one of the principal strategies they adopt.

Most of the male respondents said that they had tried to hide the problem of drug dependence for quite a long time. However, all of them failed to do so. The family members and the loved ones of almost all the men who were interviewed know about their drug addiction. The men named caring for loved ones as the most important reason for hiding this fact. The male respondents say that when they realized the essence of the problem of drug addiction and became aware that they had developed dependence on drugs, they also realized that it would be very difficult for members of their family to understand it. They tried to protect the family from the stress and hid the problem of drug dependence from them as much as they could.

'Yes, I always tried that, because my mother was very worried. Mother is still the closest person to a child. She observes your life very attentively. I might have hidden my daily life from my father, but my mother would have realized all this... I always tried to avoid them so they wouldn't know, so that my mother wouldn't be worried and wouldn't have to undergo it all. No mother is glad to have a drug-addicted son.' (R4, male, 20 years old, Zugdidi)

Some of the respondents said that at first they used drugs covertly, in a place remote from family members in order to conceal their drug dependence, or avoided going home in an intoxicated condition. And some of them drank vodka or other alcoholic drinks so that they could cover the evidence and their loved ones would think they were drunk and under the influence of just alcohol.

⁴³³ Goffman, E. (1963). *"Stigma: Notes on the Management of a Spoiled Identity."* Englewood Cliffs: Prentice-Hall, Inc.

⁴³⁴ Schomerus G, Lucht M, Holzinger A, Matschinger H, Carta MG, Angermeyer MC. (2011). "The stigma of alcohol dependence compared with other mental disorders: a review of population studies," *Alcohol*, 46, pp.105–12.

⁴³⁵ Corrigan P. (2000). "Mental health stigma as social attribution: implications for research methods and attitude change," *Clinical Psychology Science and Practice* 7, pp.48–67.

'Yes, first of all, I tried to hide it from my family. For some time, I managed to do so; when I was under the influence of drugs, I didn't talk with them and didn't go home.' (R7, male, 49 years old, Gori)

'I have drunk vodka many times after using drugs so that I would smell of alcohol.' (R8, male, 35 years old, Zugdidi)

The majority of the respondents also said that at the time of injecting drugs they often injected a drug into the muscle instead of the vein, so that their family members would not see the traces of narcotics on the veins. It is no wonder that absolutely all the respondents mentioned the drug policy that has recently become stricter and name the fear of being arrested and fined as one of the reasons for concealing drug use. However, in the final analysis, none of the male respondents concealed/was able to conceal his illness entirely.

'At last I was arrested in Batumi while high on drugs, and it became widely known. There was a trial.' (R6, male, 33 years old, Tbilisi)

'In the beginning, I concealed it, but later it no longer made any sense; everyone knew everything. You may try not to make them worry and not to let them see that you are going to inject drugs, but everyone knows everything.' (R8, male, 27 years old, Tbilisi)

Some of the respondents said that their family members reacted very badly resulting in quarrels, arguments, and threats. In some cases, the respondent only felt that his family members were sorry for him and they begged him to quit drugs. Only a very small number of the respondents mentioned that their families broke up because of their drug dependence. After the first shock and negative reactions were over, the family members of the majority of the respondents expressed sympathy and extended a helping hand.

'There were hysterics and shock in the family. But, in the end, you get used to everything.' (R8, male, 27 years old, Tbilisi)

All the male respondents noted that none of their family members were happy to hear about their drug dependence. The respondents underscore the fact that, although the problem of drug abuse was quite common in the country and the drugs were readily available across a large part of society, youth in particular had positive attitudes towards drugs. They were well aware of the fact that none of their parents would approve of their action and their drug use would cause great distress and concern. Therefore, in the beginning, the reason for concealing drugs was their willingness to avoid the wrath, anger and concern of their parents. They were protecting both their reputation in their parents' eyes,

and themselves. The reasons for concealing drug use changed and became one of the means of fighting stigma when the situation changed in the country and the State declared zero tolerance against drug abuse and declared drug abusers criminals.⁴³⁶

'Yes, first you were a good guy and then suddenly turned into a criminal, but actually you are not a criminal at all. Society was told to avoid us, that we are bad people, dangerous. Consequently, society rejected people like us.' (R6, male, 33 years old, Tbilisi)

'Stigma appeared as soon as drug abuse was criminalised... We were scared of arrest, rejection... You live in constant fear and when you see the way they treat people like you, how people avoid them, harass and despise them, you only think about the ways to hide your problem; you try to pretend as long as possible in order not to share their fate.' (R7, male, 37 years old, Tbilisi)

In the opinion of almost all the male respondents, society views drug dependence as a crime rather than a disease. Several respondents emphasized that all individuals with drug use problems are treated the same way; a person may be blamed for bad behavior due to his/her dependence on drugs, or, conversely, society may explain a person's bad behavior by his/her drug addiction. One of the respondents even says that society does not differentiate permanent users of drugs from those who have only tasted drugs once. The male respondents noted that the attitudes to them are very negative, which is manifested in different things, ranging from a change in the expression of the faces of people around them to finger-pointing and negative comments about them. Some respondents pointed out that society's negative attitude is also manifested in the fact that they have no chance of employment, as friends and relatives avoid involving drug users in business. According to the respondents, their opinions are not considered as competent, and the degree of trust in them is low, especially in matters of money. The drug-abusing men noted that the degree of trust does not tend to increase even after they quit drugs, because the conviction that there is no such thing as a 'former drug addict' is strongly entrenched in the society.

'There are difficulties in the sense that drug users are associated with criminals, and there is a strongly entrenched opinion that drug use is connected with a criminal mentality; the state has played a very big part in convincing people that a drug user is a murderer and seller of his wife and children.' (R6, male, 38 years old, Gori)

⁴³⁶ Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013.

'Almost everyone avoids drug-dependent people. Based on my own example... even a relative has refrained from involving me in a business because I was dependent on drugs. He thought that, since I needed money, I might spend the funds of the business on drugs, despite the fact that I am his relative and friend.' (R4, male, 20 years old, Zugdidi)

It is clear from the male respondents' talk that at first they tried to hide their problems from their family members, because when they faced the problem of drug abuse they feared their families' reaction and were ashamed of themselves. At the time they were not commonly stigmatized by society and they were not concerned about it. But when many reforms were implemented at state level and a new stereotype – drug abuser is a criminal – was introduced, individuals with drug use problems came across a far more severe and serious problem; their drug dependence problem automatically made them criminals and society perceived them, successful and good guys in the past, as ruthless and awful individuals and so started to reject them. Consequently, drug users found themselves in a situation where one-time successful people became discriminated against and stigmatized.

Major, B and O'Brien, L. (2005) explain that individuals who experience stigma share the opinions and look at themselves from the point of view of the society they live in; they are very well aware of their stigmatized status.⁴³⁷ They understand that they are viewed as second class citizens and recognize the fact that they can be discriminated against. Almost all members of a culture, including stigmatized people, know about cultural stereotypes, even if they do not personally support them. They also know what ideologies dominate in their culture and how society explains why different groups have the status that they do.

The state has played a large role in convincing Georgian society that all drug users are criminals and deserve the stigmatized status. This fact is clearly demonstrated by the speech (see full text of the speech in Chapter 3) delivered in Parliament, in 2006, by Mikheil Saakashvili, President of Georgia at the time, in which he named all drug users criminals and declared zero tolerance for substance abusers. He even noted that all drug users deserve imprisonment and that, if necessary, many prisons would be built in Tbilisi in order to free the country from drug addicts.⁴³⁸ As I already mentioned in Chapter 3, the tightening of the drug policy took place in the context of the anticorruption reforms and for the establishment of order and rule of law the government started to use forceful methods to destroy the reverential attitude of Georgian society towards addiction and criminal groups and/or individuals.

⁴³⁷ Major, B and O'Brien, L.T.(2005). "The Social Psychology of Stigma," *Annual Review Psychology*, 56, pp.393–421.

⁴³⁸ See the full text of Mikheil Saakashvili at this link: <http://www.drugpolicy.dsl.ge/eng/news.htm>

However, the harsh drug policy was flawed in that it contributed to the creation of a strong stigma and treatment of drug users as criminal by the state, which resulted in the attachment of the stigma of 'criminal' to drug users.⁴³⁹ Furthermore, media provided systematic coverage of addiction related issues and facilitated the dissemination and establishment of state ideology (correctness of zero tolerance policy). Many TV pieces were and are aired featuring the apprehension and arrest of drug users in which the media defends the law on drug policy, describes the persons arrested for possession or use of drugs as criminals regardless of age, sex and the amount of narcotic substances, and presents their arrests as a victory of the state over drug addiction. Therefore, collective representations have a considerable effect on the way the stigmatized people perceive and assess situations involving stigma. Individuals who are stigmatized may adjust their behavior according to collective representations even if there are no signs that they are discriminated against by others and even when they are alone.⁴⁴⁰ The effect of collective representations and of the attitudes entrenched in society on the self-perception of individuals with drug dependence problems is clearly manifested when the respondents describe their behavior (drug use).

It is noteworthy that the male respondents talked much more and far more emotionally about the negative effects of drug dependence. In addition to the fact that all the male respondents called drug dependence a chronic, incurable disease and said that drug addicts are permanently sick and disabled people, they noted that, apart from physical dependence on drugs, many people also develop a strong psychological dependence which deprives them of the ability to live freely without drugs, and drugs become the most valuable thing to them. Some respondents said that even in the case of recovery from drug dependence, the desire to use drugs remains strong and, at this time, it is very dangerous to be tempted. It should be noted that the respondents talked about those wrong and condemnable behaviors and actions that a drug-dependent individual may engage in. They recognize the fact that a drug-dependent person may sell everything, steal, rob, etc. They do not deny that society has the grounds for not trusting and for being afraid of drug users, because many drug-dependent individuals commit unlawful acts. However, on the other hand, the majority of individuals with substance use problems say that they never do anything wrong, but still fall within the category of the group which is stigmatized and discriminated against.

⁴³⁹ Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at: <http://www.drugpolicy.dsl.ge/drug%20policy%20research.pdf>, Accessed: 18.03.2013.

⁴⁴⁰ Major, B and O'Brien, L.T.(2005). "The Social Psychology of Stigma," *Annual Review Psychology*, 56, pp.393–421.

'Obviously, there are many cases when people steal, rob or mug somebody for drugs, but not everyone acts like that. We cannot tar everyone with the same brush. I use drugs, but I have never stolen anything. When in need, I would ask, borrow, but never rob. But someone may be as afraid of me as of the person who steals, robs, etc.' (R1, male, 25 years old, Gori)

'It's an illness. All you care about when you get up in the morning is how to obtain and inject drugs; you want to inject it again in the evening. You are afraid to go to bed if you don't have drugs for the next morning, so that you don't get sick when you get up. You are only interested in taking drugs, nothing else.' (R7, male, 37 years old, Tbilisi)

Two significant issues manifest themselves in the information provided by the male respondents. The first issue concerns the initial reasons for concealing drug use; the fear of being rejected by society was not one of them. All of the respondents concealed their habit to avoid dissatisfaction and anger from their family members. This situation can be explained by the fact that most of them started using drugs during adolescence, before starting to live independently. When the situation in the county changed and a new stereotype – the drug user as a criminal – was introduced, concealing drug use became a means of fighting stigma. Therefore, the stigma attached to drug users is the same as the one attached to any criminal. The second issue worth noting is the attitude of family members toward males. All the respondents said that although their families were at first outraged when they found out about their drug use, none of them turned their backs on them; they even offered them support. Therefore the male respondents did not feel rejected or stigmatized by their families. The fact that they have not lost the love and affection of their families is obvious from their answers to the question if they have lost anything due to their drug dependence. When I asked the male respondents whether they had lost someone in their lives because of drug dependence, I assumed that they would talk about people who had turned their backs on them and stopped communicating with them due to their drug addiction. However, the answers given by the male respondents in all the three cities turned out quite surprising for me. Almost all the male respondents understood this question differently from its original content. The majority of them started enumerating their friends who had died because of drug addiction. It turned out that many of them had friends who had died because of a drug overdose.

'A lot of my friends have died, and I'm very heartbroken. One of them always told me not to do it, to quit it, and that it was bad. He would do it only about once a month, but we lost him. I couldn't imagine he would die because of this, but it happened. I've lost a lot of friends; a lot of young people have died because of this.' (R6, male, 38 years old, Gori)

Only after I explained to the respondents what I had meant by this specific question, very few of them said that several people, but not family members, had turned their back on them. Some of them even added that they had lost a lot of money and wealth because of drugs.

'Yes, several friends, female friends who were almost as close to me as my sisters. At first, I was really heartbroken, but then I adapted myself to it.' (R1, male, 28 years old, Tbilisi)

'Yes, an apartment in Tbilisi, also here. And money.' (R3, male, 47 years old, Zugdidi)

Based on the answers of the male respondents, we can assume that more or less the circle of those around them adapted themselves naturally to their drug dependence. At least some of them do not feel rejected by the people close to them. This, however, does not mean that these people are welcome and not rejected by society. Here, the point is how ostracized they feel both from all society and from parts of it. Some of them believe that, although society in general hates drug users, there are people whom they can trust, who have not turned their backs on them and they are content with that. Without doubt it should be noted that people's perception of a particular situation may be different from the actual situation. Many factors are at play affecting the perception of people, and these factors determine whether people view themselves as targets of prejudice.⁴⁴¹ For instance, as Major and O'Brien (2005) argue, individuals tend to notice that their social group is discriminated against, but may not apply the discrimination to themselves personally.⁴⁴² The above is quite obvious in the interviews with the male respondents, because they stressed the fact that the discrimination and stigmatization from society is directed against drug users as a group, that this group is marginalized and as a result the respondent himself feels and perceives the harshness of the stigma.

'Drug-dependent people are treated very badly.' (R6, male, 38 years old, Gori)

'We are ostracized; nobody needs a person using drugs.' (R7, male, 35 years old, Zugdidi)

'We are blamed for everything: somebody gets killed and they immediately point the finger at us, something gets stolen and we are to blame again, just because we depend on drugs.' (R5, male, 45 years old, Tbilisi)

When asked if they felt ashamed to be using drugs, 20 out of 26 respondents said 'no,' and noted that they had done nothing shameful and went on to stress the fact that they have not lost self-esteem or their identity.

⁴⁴¹ Major, B and O'Brien, L.T.(2005). "The Social Psychology of Stigma," *Annual Review Psychology*, 56, pp.393–421.

⁴⁴² Ibid.

'No. Why should I feel ashamed?! I am not ashamed- it's my life and if I've done something wrong I did it to myself. It is those who steal, kill a man, or rob people because of drugs who should be ashamed. There are many scumbags around. Why should I be ashamed? If I've ever done anything wrong to anyone, I've done it to myself and somehow I'll deal with it.' (R2, male, 44 years old, Gori)

From the first part of the above quote it is clear that this person views his drug use as a decision made on his own and holds himself responsible for it. He thinks that there is nothing to be ashamed of in his actions, because he has harmed only himself. In this case we are dealing with a personal responsibility view of addiction, which assumes that an individual views drug use as his/her personal decision.⁴⁴³ So, if the use is a personal decision, then it is not surprising that society's attitude is very intolerant and aggressive towards those who make such objectionable and harmful decisions.⁴⁴⁴

However, the argument made by this person does not necessarily mean that this person (and those 19 other respondents who said that they did not feel guilty for using drugs) does not actually feel shame and guilt for using drugs. Here, we may have a case of a strong psychological defence mechanism which replaces the feelings of guilt and shame with another type of feeling.

According to the psychological literature on drug abuse, shame and guilt are among the emotions accompanying addiction. However, different individuals try to cope with this feeling in different ways and have different defense mechanisms in order not to admit the fact that they are ashamed of using drugs, because the individuals realize that they are harming themselves and those around them, and recognizing this fact makes them even more ashamed and guilt-ridden. Therefore, because the shame is so painful, it is common for people to hide their shame from themselves by instead feeling sad, superior, or angry at a perceived insult. Other times, it comes out as boasting, envy, or judgment of others. The more aggressive and contemptuous these feelings are, the stronger the shame. In the following part of the quote *'It is those who steal, kill a man, or rob people because of drugs who should be ashamed. There are many scumbags. Why should I be ashamed?'* the aggression towards and deprecation of other people is apparent. The respondent tries to defend himself and present himself in a better light, and also tries to prove that he has only harmed himself and the only guilt is the guilt about himself.

⁴⁴³ Lloyd, C. (2010). "Sinning and Sinned Against: The Stigmatization of Problem Drug Users." Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed: 14.08.2013.

⁴⁴⁴ Roberts, J. V. (2003). *Penal Populism and Public Opinion: Lessons from Five Countries*. Oxford: Oxford University Press.

Stigma and women with drug use problems

Many studies demonstrate that women with substance abuse problems are more stigmatized by society and experience greater rejection on the part of their family and friends than men do.⁴⁴⁵ As Elisabeth Ettore (1992) argues: 'In the public sphere she (a woman who uses drugs) is a "non-woman." Her visibility is a direct challenge to the established patriarchal order ... Whether or not a female heroin addict has ever exchanged her body for drugs or money for her habit, she is characterized as an impure woman, an evil slut, or a loose woman.'⁴⁴⁶ The issue that Elisabeth Ettore (1992) talks about can be seen in the conversations with male respondents who are drug-dependent themselves. Despite the fact that the male participants of my study have experienced the negative effect of drug use on their own, when talking about women who use drugs those male respondents with drug use problems expressed very negative attitudes and described them as non-women.

'A woman with drug dependence is terrible... It's a great tragedy for a woman. I can't perceive her as a woman... Women do not do such things.' (R3, male, 33 years old, Gori)

'Women like that do not deserve respect or humane treatment. No, they are not women. A woman will never inject and if she does then she is no longer a woman...' (R2, male, 44 years old, Gori)

'You know what I think? You may consider me Asiatic, but she is still a mother; she must give birth to a child. How can she bear and raise a child if she injects?! It's impossible. She - a female drug user can not be perceived as a natural woman!' (R7, male, 37 years old, Tbilisi)

All male respondents with drug use problems interviewed by me in Gori and Zugdidi said that it was unacceptable for women to have problems associated with drug use. Some of them explained their reasoning by saying that a woman is supposed to become a mother and it is absolutely impermissible for her to use drugs, while others said that women who use drugs are absolutely immoral and devoid of self-esteem.

'Generally, I have a very bad attitude towards drug users. And I absolutely hate female users; I hate when women take drugs. I don't know, women are still... men are still different. Women should have nothing to do with drugs.' (R3, male, 47 years old, Zugdidi)

⁴⁴⁵Nancy Poole and Colleen Anne Dell "Girls, Women and Substance Abuse." Available at: <http://www.ccsa.ca/2005%20CCSA%20Documents/ccsa-011142-2005.pdf>

⁴⁴⁶Ettore, E. (1992). "Women and Substance Use." London: Mcmillan, p.78.

'When women take drugs, they change by 100 percent. They become people of the lowest level; they become, so to say, obscene.' (R5, male, 39 years old, Gori)

The male respondents said that much is required from a woman; a woman is a mother or a potential mother and a lot of things, for example, creating a warm and love-filled atmosphere in the family, depend on her. Most men explain that a woman should firstly give all of her efforts to household chores, and if drugs hinder her from being a successful housewife, she must give them up. The respondents even said that no man, whether a drug user or not, would want to have a relationship with a woman who was dependent on drugs.

'A woman is still a woman; she has more responsibilities, more is required of her; she is still a woman. There is a difference between a man and woman, right? I think that's it, otherwise both are people. In my opinion, more is required of a woman.' (R8, male, 43 years old Gori)

'You wouldn't want your girlfriend to be dependent on something. In this respect, boys and girls are different. No one likes girls who are dependent on something – on alcohol or drugs.' (R1, male, 28 years old, Tbilisi)

The talk of the male respondents about women with drug use problems confirms the opinion shared by the experts in the previous Chapter (Chapter 4). The experts said that even those men who used drugs were aggressive and discriminating in relation to drug using women. Most of the male respondents with drug use problems interviewed by me justified aggression towards women by the fact that the principle duty of a woman is to be a mother and to look after her family, so a drug-dependent woman would not be able to carry out what is referred to as her 'principal duties.' For instance, a study conducted by Laudet et al. (1999) demonstrates that men are not concerned about the drug use of their woman partner or spouse as long as they successfully carry out their household duties and look after the children.⁴⁴⁷ So, in the case of my male respondents, it is obvious that the standards and rules prevalent in society about the role of a woman as a mother, housewife, good spouse, etc., affect the way men view the women whose lifestyle does not meet the above criteria. According to Otiashvili et al. (2013) women are considered by Georgian society to be the guardians of family norms and values; their principle purpose in life is to care for family and bear children. Therefore, the behavior of women who use substances is perceived as deviant, because they do not adhere to the widely accepted social norms. For

⁴⁴⁷ Laudet A, Magura S, Furst RT, Kumar N, Whitney S. (1999). "Male partners of substance-abusing women in treatment: An exploratory study," *American Journal of Drug and Alcohol Abuse*, 25(4), pp.607–627.

these reasons women who use drugs are described as individuals who lack will or principles, and are reckless or careless.⁴⁴⁸

The absolute majority of women with drug use problems who participated in my study also said that, in general, more is required of a woman in life than of a man, and that a man ‘can be forgiven for a lot of things and a lot of things are admissible for him’ in the eyes of society. In their opinion, such action as drug abuse is absolutely inappropriate, shameful, and unacceptable for a woman. Some respondents even said that they hate women who use drugs. The female respondents explain with arguments why a woman must not use drugs. One of the reasons they name is that a woman is a mother and she has a lot of obligations towards her family and children. In addition, the majority of the female respondents think that drug-abusing women have less chance of producing healthy offspring than men.

‘It’s more shameful for a woman. She is a mother and has children...’ (R1, female, 26 years old, Gori)

‘It is still acceptable for a man, because he is still a man and, in some way, it’s more permissible for him than for a woman. You are already a mother; you are still a woman, and you must show more tenderness.’ (R7, female, 40 years old, Zugdidi)

‘It’s terrible, I hate it. I may be intoxicated myself, but I can’t communicate with a drug-abusing woman or man. I think all of them are the same. It irritates me. Women irritate me more. I’m that kind of woman myself, but still.’ (R3, female, 27 years old, Tbilisi)

‘I think that a woman still has no justification. This is my opinion and it is based on me, because I have no justification. I was born a woman, and this says everything. You are a woman and must remain a woman. Men can still be forgiven for everything.’ (R6 female, 36 years old Zugdidi)

The majority of women with drug use problems reinforce the opinion expressed by the experts that women manage to conceal their drug dependence well. In most cases family members learned about the respondents’ drug addiction, but later some of the respondents convinced them that they had quit using drugs forever, though, in fact, they continued using drugs.

‘I went up to my mom and told her I no longer injected drugs; but at the same time, I went to the countryside and injected them in secret.’ (R3, female, 27 years old, Gori)

⁴⁴⁸Otiashvili,D.,Kirtadze, I., O’Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2013). “Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers.” International Journal of Drug Policy, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

All the female respondents, except one, said that they concealed their drug dependence as much as they could, because society considers drug use by a woman much more shameful than in the case of men. The majority of the respondents (especially those in Gori and Zugdidi) said that they suffer from a terrible fear because, if their drug dependence becomes widely known and society learns about it, everyone will start to hate them and they may even lose/be deprived of their children. The women (two women) who still conceal their drug dependence to this day note that if society learns about their addiction, it will reproach and judge them and ostracize them forever.

'If you told it to people now, many of them wouldn't believe it. None of my loved ones and family members - my mother and brother - know it. I conceal it, because I'm very ashamed. They don't expect such behavior from me, and I also don't want to disappoint them. I conceal it by staying at home when I am under the influence of drugs; I lock myself up; they know that I'm not quite all right and think I want quiet. I conceal it in this way.' (R5, female, 33 years old, Zugdidi)

'It was equal to death. I concealed it, because I knew it would be a great stress for them (parents) and, if I told them about it, they would consider me their enemy. For this reason, I held back from talking about it.' (R1, female, 27 years old, Zugdidi)

Of course, some of the respondents were unable to or did not conceal their problem entirely, while, in some cases, their family members realized everything. It should not be surprising and unexpected that, according to the respondents, their family members had a lot of stress and were shocked after hearing about the problem. The majority of the respondents noted that they had quarrels and encountered threats and rejection. None of the women said that their loved ones have yet accommodated themselves to the fact of their child's drug use.

In addition, it is quite interesting to note the female respondents' answers to the question regarding whether or not they have lost someone due to their drug dependence. Unlike the male respondents, almost all the female respondents understood the meaning of the question correctly and recalled facts and stories in which their loved ones had turned their backs on them, refused to accept them, and ostracized them without explanation. The majority of them noted that, in addition to the fact that their parents have stopped communicating with them and expelled them from home forever, close friends, relatives, and most of the people who learned about their problem have also ostracized them.

'It was my cousin who learned about it first, and she reacted to it in a terrible way. She has not spoken to me since then. She told me to forget her unless I quit drugs.' (R3, female, 27 years old, Gori)

'They turned their backs on me for good and I will never mend our relationship...' (R11, female, 34 years old, Tbilisi)

'I wish I had not lived such a life; I wish I had had the brains.' (R5, female, 39 years old, Gori)

Most of the women are, first of all, ashamed of themselves and are characterized with self-flagellation and self-stigmatization, which was not observable in the case of the men. Those who have children feel ashamed. Most of the married women have children and live with their children together. Those with no children are terribly afraid of giving birth to a child, because they think that a woman with drug use problems cannot give birth to a healthy child and that the child will suffer from and be held responsible for the behavior of his/her drug-using mother all his/her life. This opinion is also confirmed by those respondents who have children and say that society also reproaches, ostracizes, and refuses to accept their children, because they are children of 'drug-abusing women.' In this context, none of the male respondents mentioned responsibility and shame regarding their children, and we can assume that none of the men face or perceive the problem of ostracism of their children by society as resulting from their drug dependence.

'I am the shortest, I'm the most useless – when I look at the girls, they are so good and pretty. I can also be like them, I am also able not to use drugs, right?' (R4, female, 30 years old, Zugdidi)

'But I'm still very ashamed today; I can't have a child because I don't want him/her to suffer because of me.' (R1, female, 21 years old, Tbilisi)

'Everyone points a finger at these children; no one wants to communicate with them after they find out that their mother is a drug addict. Why would you want to be friends with a child of a drug-addicted woman?' (R10, female, 35 years old, Tbilisi)

It is clear from the talk of the women that hiding their problems from the society is one of means of protecting themselves from stigma. However most of them have not been able to conceal the problem for good and have experienced the negative influence and consequences of stigmatization. The strong influence of stigmatization is manifested in the negative attitude towards oneself and low self-esteem. Unlike the male respondents who tried to set themselves apart from other drug users and describe themselves as different, better persons, or went to great lengths to explain their problem not by their weak will, but by situational factors, women said that they were individuals of the lowest level, indecent, unwanted and worthless. They describe themselves as other members of society, as my male respondents described them.

'How can anyone trust me? There is no one worse than me. Who can be worse than a drug addicted woman? I know that I have done a terrible thing and have to be punished for that. It tortures and worries me.' (R7, female, 55 years old, Zugdidi)

'I hate to see a man who is not sober and is under the influence of drugs... and imagine what an intoxicated woman would look like. Terrible...' (R9, female, 27 years old, Tbilisi)

A classical view on the influence of stigmatization on individuals suggests that the negative view of society shapes the inner-self of the stigmatized people.⁴⁴⁹ According to this view, stigmatized people's self-esteem is equal to the level to which they are devalued by the society. Non-stigmatized people's self-esteem is relatively higher. There is also a difference in the level of self-esteem among stigmatized people; those who are more valued have higher self-esteem than those who are less valued.⁴⁵⁰ Therefore, the respective case of women drug users perfectly fits this perspective and demonstrates that, unlike men, women assess themselves more negatively. The reason behind this fact is that women experience stronger stigmatisation, which has a negative influence on their self-esteem and self-attitude.

Another interesting point identified during the interviews with women is the stigma attached to their family members. This was not the case with male respondents. The stigma towards family members of stigmatized individuals is the courtesy stigma according to Goffman (1963), who explained it as a prejudice and discrimination that is extended to people not because of some mark they manifest, but rather because they are somehow linked to a person with the stigmatized mark. Many studies demonstrate that people who have individuals with mental health and/or drug use problems as their family members often become victims of courtesy stigma.⁴⁵¹ Corrigan et al. (2004) hold that members of an individual's family who has drug use problems, are more stigmatized than the family members of an individual with mental illness, because society blames the family members for a person's drug addiction.⁴⁵² As Corrigan et al. (2004) argue, 25 to 50 percent of family members concealed having a mentally ill family member because they were ashamed, and feared that people might avoid them.⁴⁵³

⁴⁴⁹ Major, B and O'Brien, L.T. (2005). "The Social Psychology of Stigma," *Annual Review Psychology*, 56, pp.393–421.

⁴⁵⁰ Ibid.

⁴⁵¹ Patrick W. Corrigan, Amy C. Watson, Frederick E. Miller (2004). "Shame, Blame, and Contamination: A Review of the Impact of Mental Illness Stigma on Family Members." Manuscript submitted to *Psychological Bulletin*.

⁴⁵² Ibid.

⁴⁵³ Ibid.

In the interviews of my female respondents, it is observable that their family members encounter the courtesy stigma, that the respondents understand and feel that the family members are ashamed and are afraid of social isolation because they are in relationship with the individuals whose drug use behavior is heavily stigmatized. Therefore, in order to save their family members from social isolation and in order to save themselves from ostracism women, those whose family members and loved ones learned about their drug dependence still continued to lie to those around them that they had quit this harmful habit. A number of them failed to convince their families that they were not using drugs any more. Others tried detoxification treatment several times, some of them got involved in the methadone program and some of them used harm reduction programs, however, the treatments were never as effective as the family members hoped for. Consequently, most of the women returned to drugs and had to hide their addiction again.

It is noteworthy that women cited the fear of rejection and ostracism from their family as the reason for lying again. They said that they would not be forgiven again and given another chance, so they have to lie. The women also noted that if their relatives found out that they were using drugs even after the treatment, they would blame it on their weak will, indecency, and lack of motivation and would never consider the fact that the treatment could have been ineffective itself. For this reason, the fear (of physical abuse, psychological, of being expelled from home, of being punished by taking away her children, etc.), the shame, and the remorse that these women had already experienced was partly alleviated by undergoing treatment (giving rise to hopes of reintegration with society and of complete recovery) may be renewed by repeated use of drugs. These women still conceal this fact and now find themselves in a much more difficult state.

'I conceal it all the time; members of my family are still unaware of it. They have heard about it before, once or twice. When I needed help with hospitalization, they, of course, helped me. Since then, they think I quit it.' (R1, female, 21 years old, Tbilisi)

'Society will ostracize you; it has ostracized you once and it will ostracize you forever if you do it again. They trusted you and you disappointed them? They will blame you; they will tell you that you are bad, you haven't been able to refrain from doing it and injected drugs again. It will occur to no one that treatment is not about one or two transfusions only.' (R9, female, 27 years old, Tbilisi)

According to Otiashvili et al. (2013), women can feel bad about their using drugs. They are ashamed of what they have done and do not want to talk about it with their family or friends. This reluctance to disclose their behavior extends to non-family members and even to healthcare providers.⁴⁵⁴ From some accounts of interviews with women who are dependent on drugs, presented by Otiashvili et al. (2013), it is obvious that when these women tried to look for help outside the family their family members were against letting other people know about their substance use problem. This created an additional barrier for women who wanted to undergo treatment. However, there were many cases where the family offered support and was the one to make the decision to seek treatment, to finance it, and to look after the children of their drug-dependent family member. But, after giving support to a person with substance use problems, the family expects the person they stood by to quit drugs and recover.⁴⁵⁵

The fact that the family expects the treatment to be effective can be quite a sensitive matter in the case of women. The female respondents touched on this issue and demonstrated the difference between the family support provided to men and women.

'I am hiding it in order for them to think that it's over and I am cured, but how can a few blood transfusions cure you completely? They just don't understand that it's not so easy, but if they find out that I am still injecting they would not believe that the treatment was not enough or effective. They would blame me for everything again.' (R3, female, 27 years old, Gori)

'I have a friend whose family spent a lot of money on her treatment, but she could not quit and the family banished her, left her to her own devices, because they don't believe that the girl tried her best, and could not have been cured in a few months. Understandably, family members want you to quit in a few days, but they don't understand that drug dependence is not flu to recover from in three days, and it's not your fault that the treatment is not effective.' (R2, female, 29 years old, Gori)

When talking with women about concealing their drug dependence, several important issues came to the fore. Firstly, the significant impact of stigma becomes obvious, which is largely discussed by the interviewed experts as well as in international studies and by researchers (see previous chapters). It is also clear from the answers of female respondents' that women have far more to lose than men do and experience stronger fear and psychological pressure. When male respondents reveal their problem to their families they no longer have to hide it in the future, because most of them get support from the

⁴⁵⁴Otiashvili,D., Kirtadze, I., O'Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012). "Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers." International Journal of Drug Policy, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

⁴⁵⁵ Ibid.

families. On the other hand, women are rejected, ostracized and condemned by their friends and family. They are tortured by the thought that their children will be taken away and even if the family provides support and finance for treatment, women still have to lie if the treatment proves ineffective.

When women return to their old habits after receiving treatment, the relatives blame women's feeble nature, weak will and other personal weaknesses, and nobody doubts the effectiveness of the treatment. In the case of men, given that traditionally they are considered strong and determined, it is hard to blame their feeble nature for the ineffectiveness of treatment.

Conclusion

This chapter demonstrates that there are differences in the case of men and women when it comes to drug use reasons. Social factors and environment appear to be main factors triggering men's drug use. A circle of friends, which had a great influence on the behavior of adolescents, as well as the trends and situation within the country in the 1990's played a significant role in the formation of the wish and of the reason for the male respondents to taste drugs. Many of them admitted wanting to become a member of the society where drug use was considered good form and drug users were role models.

In the case of women, rather than social and/or environmental factors, strong feelings of shame and guilt and sentiments of 'end-of-life' come in at first place. Despite the fact that in many cases interest and the availability of drugs appeared to be the main factor triggering women's first drug use, the reason for repeated and systematic use is the ability to escape from reality. This is especially true for the women from rural regions (Zugdidi and Gori). A considerable number of female respondents acknowledged that severe psychological terror in the family, continuous insults from their husbands, lack of love and peace, absence of support and stability motivated their wish to escape from reality with the help of drugs. Another serious reason for drug use in women is related to their sexual partner. As a result of cohabitation with man who was drug-dependent, some of the female respondents developed a desire and interest to taste a narcotic substance, while, in some cases the use of substances was forced. This chapter makes it clear that most often men benefit from their female partners using drugs. Men's desire to offer drugs to his partner is connected with the willingness to increase his power and control over her. The examples provided by the respondents clearly demonstrate the cases where women were forced to use drugs for the purpose of exercising direct control over and subordinating them. The stories shared by the respondents reveal oppressed women who are trying to escape from reality through drugs. Their reality includes their subordinated, unequal, oppressed position which they are trying to

escape. The examples provided by the respondents also show that women suffer from other mental health problems and have much more to lose because of their drug use habit.

Society tolerates men's drug use much more and women are perceived as failing as mothers, sisters, daughters and spouses. Therefore, men and women adopt different strategies to struggle against the stigma attached to their identity because of their drug use problems. Women try to conceal their drug dependence problem as long as they can in order to avoid stigma and discrimination against themselves as well as against their family members. Women are discriminated against by the whole of society and, unlike men, even their family members turn back to their needs and problems and reject them. The strong influence of stigmatization in the case of women is manifested in the negative attitude towards oneself, and low self-esteem. Unlike with the male respondents who set themselves apart from other drug users and described themselves as different, better persons, or went to great lengths to explain their problem not by their weak will, but by situational factors, women placed themselves belonging to the group of individuals of the lowest level; indecent, unwanted and worthless.

Chapter 6

Drug Treatment: Barriers and Solutions

Introduction

Individuals with substance abuse problems generally believe that if they undergo treatment they will achieve successful results.⁴⁵⁶ But in order to achieve the desired results they have to start the treatment. The fact is that many individuals with drug dependence face a number of problems on their way to enrolling in treatment. Various studies suggest that these problems are mainly structural, cultural or internal. But in Georgia there are several local specific obstacles which were already mentioned: money, poverty, legislation, no available treatment, the medical model of drug treatment, etc. The most direct way to get a clear picture about what prevents individuals with substance abuse problems from engaging in treatment is talking to them; however, the needs of drug-dependent individuals are not

⁴⁵⁶ McLellan AT, Alterman AI, Metzger DS, Grissom GR, Woody GE, Luborsky L, et al. (1994). "Similarity of outcome predictors across opiate, cocaine, and alcohol treatments: Role of treatment services," *Journal of Consulting and Clinical Psychology*, 62, pp. 1141–1158.

always taken into account.⁴⁵⁷ To find out whether the respondents wanted to stop using drugs, what methods they tried to break themselves of the drug habit, and what kind of difficulties they face while using treatment services, I talked to both male and female respondents about treatment, problems associated with treatment, and the ways of solving them.

Problems and barriers

As it turned out the key motivation for seeking treatment in the case of male respondents was their desire to deal with deteriorating health problems and to find a job. Nearly all the male respondents expressed the wish to return to ordinary life. In addition, they wanted to live quiet lives together with their families, spouses, and children. All the male respondents noted that they wanted to get a job or start some business, which is a serious problem in the present reality because it is practically impossible for an individual with drug use problems to get a job. Accordingly, they are motivated to quit drugs in order to get a job.

'When you have everyday problems, you don't even have enough time to think about health. There are so many problems at home that I take drugs now in order to be able to move and walk.' (R7, male, 49 years old, Gori)

'I would, first of all, name family and family members, then perhaps love and friends; a lot of reasons. You can be motivated by these three main things. These are the main things you can take this step for.' (R3, male, 33 years old, Gori)

'Myself. If I'm not well, I won't be able to do anything for my child, wife, and friends. If I'm not well, I won't be able to do any of these things. Talking about giving love, I may give love even when I inject drugs, but it does not reach the addressee; it gets blocked when my wife and child see that I'm high on drugs. No one needs your hugs and embraces. When they know that you are well, you try to start a job and to get back. Self-respect is also involved here. When you are a drug addict, they look at you differently, and you want to prove them wrong.' (R6, male, 33 years old, Tbilisi)

'Starting a job is perhaps the strongest motivation, because nowadays it is very difficult to make money. This is my motivation, because I know that when I have given this up, I will get a job. I've talked to a couple of people about this. They gave me hope, but I don't know for sure. The main thing is

⁴⁵⁷ Tsogia D, Copello A, Orford J. (2001). "Entering treatment for substance misuse: A review of the literature," *Journal of Mental Health*, 10, pp.481–499.

to really want to do it, and if you take this step, you must take it to the end. The fact remains that I'm not yet ready for it. (R8, male, 28 years old, Zugdidi)

When talking about problems related to treatment, male respondents highlighted the hurdles on their path to treatment services in Georgia. The first key factor cited by most of the respondents was the high price of treatment services, which they cannot afford.

Normally, drug treatment in Georgia comprises a detoxification course that lasts two weeks. After this course, patients are discharged and only receive outpatient treatment from one to six months. The treatment focuses mainly on abstinence and is financed by patients. Many patients cannot afford to pay for their outpatient treatment because prices vary from GEL 1,250 (570 EUR) to GEL 2,250 (1.020 EUR) for a 9-day detoxification course, together with a two-week initial rehabilitation.⁴⁵⁸ It turned out that most of the male respondents (those undergoing treatment at the time of the interview and those not using treatment or harm reduction services) have resorted to self-treatment because of the exorbitant prices. The respondents list many cases when either they and/or their acquaintances and friends prescribe themselves or other people certain medicines to overcome abstinence without consulting a doctor. It seems that self-treatment is very common among those who participated in my study. For them, self-treatment means overcoming withdrawal symptoms without any medical consultation and professional assistance. For this purpose they take various psychotropic drugs and analgetics which alleviate pain and bring emotional calm. They exchange information on various medicines and the means of overcoming pain or withdrawal symptoms and give advice to each other and assist each other by experimental means. Individuals resort to self-treatment because of financial hardship and the fear of the penitentiary system. And the fact that most psychotropic and analgesic drugs used to be available at pharmacies without prescription, encouraged self-treatment in addicted individuals.⁴⁵⁹

I have not taken treatment. One can only administer self-treatment, if I speak based on my example. Previously, there used to be Tramal, "Tetrad", and Cetalgin which I used to satisfy myself. Sometimes,

⁴⁵⁸ Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). "Drug Situation in Georgia – 2012," Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

⁴⁵⁹ The situation started to improve from 2014. Control over the sale of medications without prescription was tightened and, at the initiative of the Ministry of Health of Georgia, the procedure for issuing Form #3 prescriptions will be introduced gradually and strong medications will not be available without a doctor's prescription. Two main reasons for introducing prescription on strong drugs are: increase in what is referred to as 'pharmacy addiction' and high rate of self-treatment-induced health complications. For details see: <http://www.radiotavisupleba.ge/content/drug-addiction/25233362.html>

I had falls, or periods when I quit drugs, when I didn't have money and drugs were also unavailable.”
(R5, male, 39 years old, Gori)

'The biggest problem is money....' (R6, male, 35 years old, Zugdidi)

'I have tried self-treatment many times. Guys shared their personal experiences of such treatment. Every one of them had a suggestion about what to take to cope with withdrawal symptoms. Yes, it is hard, but what else can you do when you are broke?' (R6, male, 38 years old, Zugdidi)

'I have undergone detox treatment, and been in hospital, but you can't afford it all the time because you hate to cough up so much money and often because you don't have any money. So I have sometimes locked myself out and tried to deal with withdrawal by administering various spasm relieving drugs. Then you start again, later you quit again, and these phases alternate...' (R6, male, 33 years old, Tbilisi)

Apart from the financial hardship and high cost of current treatment services, another key problem named by the male respondents is the ineffectiveness of treatment.

Both groups of male respondents (those who have undergone a drug treatment course in a medical establishment and those who have not) believe that treatment in Georgia is ineffective. Those respondents who have undergone treatment services (or are in treatment) noted, on the basis of their own and their friends' experience, that they still resumed using drugs after the treatment. The respondents also point out that the treatment process is mainly oriented to removing physical dependence, while they believe that psychological dependence is a much stronger factor and should be paid more attention to.

'I know people who have quit, but then I heard that they still took drugs in secret.' (R2, male, 44 years old, Gori)

'There is no serious treatment program in Georgia yet. The programs that exist here are not good enough. They are only oriented to removing physical dependence. One or two years may pass; some people paid thousands of Lari and spent six months lying in a hospital room, but a year later they still started taking drugs again.' (R5, male, 39 years old, Gori)

'Two weeks is not enough. As far as I know, treatment continues for years abroad. In two weeks, you can go cold turkey, but you can't be cured psychologically. There is also a lack of psychologists; there are those who are competent, but there are also those who may ask you why you injected. This is not the kind of treatment that it's supposed to be.' (R8, male, 27 years old, Tbilisi)

'I have three friends who have been hospitalized; they also received treatment in Tbilisi and still injected drugs during the treatment process... there are medicines that help you go cold turkey without pain. In this respect, it's comfortable, but you still have the insomnia. These medicines have a terrible effect on a person.' (R6, male, 38 years old, Gori)

The male respondents say that when patients are discharged from a medical establishment after paying inconceivably high fees and undergoing the treatment process, they are faced with a cruel reality in which they do not know what to do, and idleness and helplessness often prompt them to use drugs again. It must be noted that at the time of the interviews only two respondents were undergoing psycho-rehabilitation and from their interviews it is clear what a crucial role a psycho-rehabilitation component plays and only through that psycho-rehabilitation were they able to overcome the desire to take drugs. These two respondents who were the beneficiaries of organisation Kamara, had tried detoxification treatment many times and every time that short-term treatment was ineffective and every time they had returned to drugs. Kamara offers its users different activities besides psychological consultations, which were mentioned by the respondents as particularly important.

'It's very easy to get rid of the withdrawal symptoms. What happens next is what really matters. In Georgia, the best organization in this respect is Kamara, but it is not a large scale one. There are only 20-25 patients. Considering that, at the same time 10,000 people are undergoing detox treatment and only 30 individuals out of those people are in Kamara, the situation is very grave. It's a drop in the ocean. In this organization you are provided exactly with the treatment necessary for drug-dependent individuals. They provide psychological assistance. Psychological rehabilitation is crucial. After withdrawal symptoms the most difficult part is when you wake up in the morning and don't know what to do. At that time you have no goal and just stare at the ceiling and eventually go back to drugs. Nobody can deal with it by just staring at the ceiling. A person has to do something. In Kamara the situation is ideal in that respect. In the morning when you get up you know that you have to go there, paint, model, sing, work out, express thoughts, and be busy. I have the desire to take a bath, dress up and look nice. When a drug user completes treatment he/she has to do something. After one year he may say that he got used to a drug free life. I made a small town out of cardboard for an exhibition, and I named it 'Kamara.' That work proved to be a good distraction for me. I was so absorbed in it that I did not remember anything. It isn't difficult, is it? When a drug user leaves a treatment facility- to give him a cardboard box and tell him to make something out of it. But in order for him to make anything, to engage in some activity, you have to help him through psychological rehabilitation.' (R7, male, 37 years old, Tbilisi)

Several respondents had interesting attitudes towards the methadone substitution therapy. Some male respondents expressed particular aggression and a negative attitude to this program and described it as a program which is as ineffective as detoxification and which damages a person's health. A large number of male respondents said that instead of helping users, methadone acts as an ordinary narcotic substance, but does not satisfy them. Due to this, the respondents mentioned many cases when individuals involved in the substitution therapy add other narcotic substances to methadone.

'The Methadone Program is like signing consent to your own death... Methadone itself is a medication that ruins the entire organism, and it doesn't matter whether you die in a year or three years, you die anyway. [How do you know this?] From my narcologists, those who work in the drug treatment clinic - the attending doctors. There are people who have the potential to quit drugs and there are those who don't, right? The people involved in the Methadone Program are those who don't. They give them an official document which says that they are drug addicts and they kill them slowly.' (R1, male, 28 years old, Tbilisi)

'They have no idea what they are doing. They quit heroin and start methadone. I think it's utter nonsense... It doesn't matter what drug you depend on, the actual fact of dependence is what matters...' (R10, male, 33 years old, Tbilisi)

'It's very bad, you depend on it as on any other drug... You can't function without it... You are hooked on that drug, and does the name it really matter?' (R8, male, 28 years old, Zugdidi)

From the male interviews it is obvious that barriers to treatment are related to financial issues (high cost of treatment services) and distrust towards treatment. Based on personal experience, all the respondents (those who are receiving treatment and those who are not, those using only harm reduction services and even those two Kamara beneficiaries) believe that, generally, treating drug dependence in Georgia is ineffective, because it is aimed solely at the removal of physical dependence, with no attention given to psychological rehabilitation, which is one of the key components in treatment. Otiashvili et al. (2013) also mention the existing prejudice related to medication-assisted-treatment programmes in Georgia. Otiashvili et al. (2013) found that potential patients often viewed the medication-assisted-treatment as a 'last resort' option, for the most disadvantaged and failing substance-abusing individuals.⁴⁶⁰ Like my respondent, the participants of the Otiashvili et al. (2013)

⁴⁶⁰Otiashvili, D., Kirtadze, I., O'Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2013). "Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers." *International Journal of Drug Policy*, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

study viewed entering medication-assisted treatment as equal to admitting ultimate failure and belonging to ‘those on the bottom’⁴⁶¹

International literature also questions the effectiveness of methadone therapy and treatment. According to Lloyd (2010), a number of authors have pointed to the special stigma associated with methadone substitution treatment – and, in particular, methadone maintenance, where users are prescribed methadone for a prolonged, indeterminate period (rather than being on a reduction schedule, to assist with detoxification).⁴⁶²Lloyd (2010) explains the reason for that wrong and distrustful attitude towards methadone is the stigma which is based on the opinion that substitution therapy is perceived not as treatment but as replacing one narcotic substance with another.⁴⁶³ Some male respondents showed signs of a stigmatizing attitude towards those who are enrolled in methadone treatment.

The respondents undergoing methadone treatment did not show any aggression towards this program, yet they noted that substitution therapy is not adequate, and like detoxification, does not treat psychological dependence, which they think is a major problem irrespective of the treatment method when it comes to drug dependence.

‘What can I say about methadone? It really helped me to a certain extent. I no longer have withdrawal symptoms, but I don’t like the fact that it does not include psychological rehabilitation. This service is presented as a separate service, when, in fact, it should be included in methadone treatment. Believe me, it makes no difference whether you undergo detox or participate in methadone treatment, nothing will help you unless you are strong psychologically, unless you are brought to the state where you can function independently... I come here every morning, take my daily dose and leave, but I understand that I need some kind of additional assistance, psychological consultations, advice, talk, well, you know, rehabilitation...’(R4, male, 29 years old, Tbilisi)

It is noteworthy that all respondents, irrespective of their treatment record, agree that the main problem in Georgia in relation to existing drug dependence treatment services is the lack of psychological assistance and the absence of occupational therapy and trainings for developing professional skills.

‘When in treatment you need some incentive, you have to be busy with something to avoid continuously thinking about drugs. Therefore, I think that work therapy is crucial in this process. You are occupied

⁴⁶¹Ibid.

⁴⁶² Lloyd, C. (2010). “Sinning and Sinned Against: The Stigmatization of Problem Drug Users.” Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed: 14.08.2013.

⁴⁶³ Ibid.

with something, time passes, and you know that you've got work to do that will keep you busy all day long.'(R3, male, 47 years old, Zugdidi)

'Idleness at this time is disastrous. You've no idea what it's like to be without drugs. You know nothing, you are naked. You don't know how to get on in life. You start learning everything from scratch... You are not used to walking around or thinking in a sober state. And the only thought that comes to mind is drugs. That's why it is very importance to occupy yourself with something, to become distracted, have some fun. But in this case I do not mean watching movies or reading a book. It won't help you. You have to find work to do. First it will be difficult, but later on you'll be able to overcome thoughts about drugs or temptation. Anyway, I believe that it would help me. Currently, I am unemployed and I only have drugs on my mind. If I were in treatment, and by the way, when I was in treatment it was idleness that ruined me. Every time I returned home I had nothing to do, no routine, no reason to get out of bed, nowhere to go. So I couldn't resist the temptation and ended up using again...'(R7, male, 49 years old, Gori)

'You need some kind of motivation, especially when you are trying to get cured, and the best motivation at this time is the ability to work. But where? Just imagine you are a drug addict, where can you find work when even normal people are out of jobs? There should be some training, courses for developing professional skills. Such trainings would be beneficial in many respects, not only in the future when you are cured and ready to work, but also in the course of rehabilitation. When you are occupied, you manage to think about something else other than drugs. There is no spare time for bad thoughts. At the same time you need this for proving to yourself that you are still capable of doing something.'(R8, male, 28 years old, Zugdidi)

Studies have shown that if an individual has a job at the time of treatment, he/she stays in the treatment for a longer period and the rate of successful treatment is higher.⁴⁶⁴ Employment is also believed to reduce the likelihood and severity of drug relapse and help individuals acquire new sober friends, learn new ways of interacting with people and remain sober.⁴⁶⁵ French et al (1992) suggest that although individuals with drug use problems are often willing to acquire new professional skills and receive vocational training, their desires are seldom fulfilled.⁴⁶⁶ French et. al. (1992) state that clients willing to engage in a vocational activity or to get employed may think that they are qualified for a particular job,

⁴⁶⁴ Platt, J.J. (1995). "Vocational rehabilitation of drug abusers," *Psychological Bulletin*, 117(3), pp. 416–433.

⁴⁶⁵ Ibid.

⁴⁶⁶ French, M.T., Dennis, M.L., McDougal, G.L., Karuntzos, G.T., and Hubbard, R.L. (1992). "Training and employment programs in methadone treatment: Client needs and desires," *Journal of Substance Abuse Treatment*, 9(4), pp. 293–303.

however, in fact they may lack the necessary skills for that job.⁴⁶⁷ Therefore, they should first engage in educational programs, acquire the required skills and then move on to the new job. Traditional vocational services are focused on raising self-esteem, training in social skills, monitoring and assessing the achievements of clients, and providing basic education. Apart from the fact that such services facilitate employment and financial independence, they also have positive influence on individuals with drug use problems by raising self-esteem and confidence if applied in the course of treatment. The above is also obvious in the case of those two respondents who are engaged in various work activities in Kamara.

'When you are painting and you know that you have to paint because you have been assigned a task which has to be fulfilled, even when you are carving something out of wood, it helps me more. It helps me to get my mind off bad thoughts; I become totally engrossed in that process, and develop more confidence in my abilities. I learn something new every day and now I can make hand-made items, sing, create something, and be proud of myself.' (R7, male, 37 years old, Tbilisi)

It is a generally recognized fact that occupational therapy is one of the key components in the course of drug dependence treatment but in Georgia the use of occupational therapy is quite rare and is mostly practiced by psychological health centers. Among those organizations whose patients were my respondents, only Kamara uses occupational therapy during addiction treatment. In Kamara occupational therapy includes painting, modeling and different needlework, in which beneficiaries are engaged.

In Georgia, occupational therapy is more often used to improve the psychosocial rehabilitation process in mental health and psychiatric facilities in Georgia. For example, with the assistance of the instructors at the National Center of Mental Health, beneficiaries were engaged in garden improvement works and, according to Center representatives, working in the yard enabled the beneficiaries to maximally use their physical, emotional, cognitive, social and functional abilities, as well as to restore, develop and acquire those skills that are essential for independent functioning, health and a better quality of life.⁴⁶⁸ However, I believe that this area of rehabilitation is rather undeveloped, and a number of journalistic articles and blogs prove my point. They state that (as there are no studies in this area) workers in the

⁴⁶⁷ Ibid.

⁴⁶⁸ For additional details see: <http://www.ncmh.ge/fsixo2.php?action=8>

area of mental health have quite vague ideas about occupational therapy and often they regard the exploitation of their patients/beneficiaries as rehabilitation.⁴⁶⁹

Individuals undergoing detoxification treatment or rehabilitation may use occupational therapy services. Such services offer clients counseling in group and face-to-face settings and also develop confidence, self-esteem and social skills. In order to deal with the complicated nature of addiction, a variety of skills and methods are required. In this regard, the technique used by the occupational therapy is based on learning useful skills while being engaged in some kind of activity.⁴⁷⁰

The interviews conducted with the respondents on the subject of treatment and the problems associated with treatment reveal not only the fact that the resources of Georgian-based services are scarce, but also the fact that the needs of many clients who require such services are not met.

The problems mentioned by the male respondents in relation to treatment services reveals the fact that the key principles underlying the effective treatment are not observed.

The National Institute on Drug Abuse (NIDA)⁴⁷¹ outlines 13 main principles of effective treatment in the third edition of the ‘Principles of Drug Addiction Treatment: A Research-Based Guide’ and states that because drugs of abuse alter the brain’s structure and function, resulting in changes that persist long after drug use has ceased, individuals with addiction problems are at risk of relapse even after long periods of abstinence and despite the potentially devastating consequences.⁴⁷² This definition confirms that a short-term treatment course does not mean that a patient is cured and the patient, as well as his/her parents, loved one’s and treating physician should not expect that there will be no drug relapse. Most of the male respondents who applied to a treatment facility expected to get cured upon the completion of the first treatment course. Later, when they faced the reality and returned to drugs after a two-week detox course, they considered the treatment to be ineffective. According to the National Institute on Drug Abuse, for a treatment to be effective a patient should remain in it for a sufficient period. It takes a long time and multiple stages of treatment to recover from drug addiction. Drug abuse is similar to other chronic diseases, in that there is a chance of a relapse and when it occurs the

⁴⁶⁹For additional details see: <http://www.liberali.ge/ge/liberali/articles/100916/>

⁴⁷⁰Clarey, L. and Felstead, B. (1990). “The Contribution of Occupational Therapy to Alcohol and Drug Rehabilitation: A Descriptive Review,” *Australian Occupational Therapy Journal*, 37, pp. 85–88.

⁴⁷¹The National Institute on Drug Abuse (NIDA) is a United States federal-government research institute whose mission is to “lead the Nation in bringing the power of science to bear on drug abuse and addiction.” See details at:

http://en.wikipedia.org/wiki/National_Institute_on_Drug_Abuse and at: <http://www.drugabuse.gov/>

⁴⁷²National Institute on Drug Abuse (2012). “Principles of Drug Addiction Treatment: A Research-Based Guide” (Third Edition). Available at: <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>, Accessed: 10.02.14.

individual should undergo a new treatment or adjust the current one. As there are many cases of early drop outs from treatment, programs should find ways to keep their clients.⁴⁷³

Accordingly, the frustration and distrust observed in the interviews with my respondents towards existing treatment facilities is a result of the violation of the above principle; they did not expect the treatment to take so long and it is not surprising. The respondents used the services offered to them, the services that lacked that crucial component that the respondents needed. Many respondents had applied for detoxification treatment and undergone a two-week course and expected to see positive results. Such misguided expectations of individuals seeking drug-dependence treatment are a clear indication of the improper functioning of treatment facilities and lack of information and resources.

The NIDA explains that **detoxification is only the first stage of addiction treatment and is not sufficient for curing long-term drug abuse.**⁴⁷⁴ It rids addicts of withdrawal symptoms and can be an initial step to effective long-term addiction treatment. Therefore, following detoxification, patients must be motivated to remain in treatment. In the case of the respondent we get a completely different picture, where addiction treatment is limited only to detoxification, which violates one more principle offered by the NIDA stating that patients should be assigned treatment according to their individual needs. The NIDA explains that treatment conditions, counseling and services should be adjusted to a patient's specific needs so that the individual can successfully function in the family, workplace, and society.

The need for multiple treatment services can be observed in the interviews with my respondents when they talk about the necessity of psychological rehailitation, occupational therapy and vocational training courses. The respondents, based on their own experience and that of their acquaintances came to the conclusion that they need much more than the treatment services are currently offering in Georgia. One of the crucial factors upon which the solution of all the above-mentioned problems depends, is easy access to treatment services. Not matter how sophisticated and diverse the existing services may become, the clients will still be confronted with a serious problem unless such services are easily accessible. The male respondents say that treatment is very expensive and it is logical that even if they desire to receive treatment they refrain from doing so because of the exorbitant cost of the treatment the effectiveness of which they doubt, it being limited to one particular service, the

⁴⁷³ Ibid.

⁴⁷⁴ Ibid.

deficiencies of which are apparent. The fact that treatment is not easily accessible in Georgia contradicts yet another principle laid down by NIDA.

The NIDA states that **treatment needs to be easily accessible**.⁴⁷⁵ Individuals with drug-abuse problems may hesitate to start treatment, so it is important that the services are readily available at the moment the individual decides to enter treatment. If an individual with drug addiction sees that treatment is not easily accessible he/she may change his/her mind.

Difficulty in accessing treatment services has an actual impact on the decisions of individuals to start treatment. The problems referred to and discussed above in relation to treatment processes constitute a structural barrier faced by individuals who have dependency problems. Apart from structural barriers, one of the significant problems clearly demonstrated in various studies is related to stigma and is one of the reasons holding back drug-dependent persons from seeking treatment. Interestingly, when talking about treatment only a four male respondents touched upon the problem of stigma and acknowledged it as being one of the serious problems preventing a potential patient from engaging in treatment.

'Stigma and fear of discrimination, these are the factors that may discourage you from applying to a treatment facility.' (R10, male, 33 years old, Tbilisi)

However, it must be noted that when talking about stigma, none of the male respondents had the medical staff in mind. On the contrary, those who have been to a medical facility at least once and have undergone treatment spoke highly of the doctors and said that although the service itself was ineffective and limited, the attending staff were very obliging, helpful and sympathetic. The few respondents who cited stigma as a barrier to treatment explained that fear of rejection and stigmatization often puts individuals with drug abuse problems in a difficult situation and makes them refuse treatment. However, none of them specified that this was the reason behind their decision to refuse to receive treatment.

'Yes, of course you are afraid of being rejected, and when you come back and they know that you've received treatment, they still don't believe that it's over and that you'll start living a normal life. But, no matter what, you still fear, you can't be rejected more if you're already rejected, so that fear is not what prevents you from engaging in treatment. The reason is the money, or rather lack of it, or if you have it, you still don't want to waste money. Yes, it's wasting. When you know that you'll resume injecting after a month, why would you waste it?' (R5, male, 45 years old, Tbilisi)

⁴⁷⁵ Ibid.

Four major problems have been identified in the case of men based upon their experience: difficult access to treatment services, limited nature of the services comprising only detoxification or methadone substitution therapy, shortage of psychological rehabilitation services and doubting the effectiveness of said services.

Women-oriented treatment services

Problems and barriers mentioned by male respondents are also evident in the interviews with female respondents. However, research indicates that, among other differences listed in previous chapters regarding drug use, women generally have more severe problems and face greater obstacles while accessing treatment as compared with men.⁴⁷⁶

The United Nations Office on Drugs and Crime Report (2004) states that women around the world have similar difficulties on the way to entering and staying in treatment.⁴⁷⁷ These difficulties are mostly connected with their roles as wives or mothers, as well as with having a drug-dependent sexual partner. Women also say that the fact that they are more stigmatized than men is an additional barrier to seeking treatment.⁴⁷⁸ Studies demonstrate that family relationships, fear of being deprived of custody of children, inability to make decisions without their partner's consent, and fear of being rejected by their own children are among the problems that are usually associated with engaging women in treatment. Overall, studies throughout the world have revealed that women who are willing to start treatment often face social, cultural, systemic and personal barriers. Such barriers should be considered when designing treatment services for women.⁴⁷⁹

A study carried out in Georgia by Otiashvili et al (2013) on women with drug-dependence confirms that one of the principle barriers to accessing treatment is the fear of stigmatisation.⁴⁸⁰ Women may become victims of stigma not only from society but also from medical staff; and this fact has even been confirmed by the interviewed women.⁴⁸¹

⁴⁷⁶Nelson-Zlupko, L., Kauffman, E., Dore, M. M. (1995). "Gender difference in drug addiction and treatment: Implications for social work intervention with substance-abusing women," *Social Work*, 40(1), pp. 45-54.

⁴⁷⁷ United Nations Office on Drugs and Crime (2004). "Substance abuse treatment and care for women: Case studies and lessons learned." Available at: https://www.unodc.org/docs/treatment/Case_Studies_E.pdf, Accessed: 5.12.13.

⁴⁷⁸ Ibid.

⁴⁷⁹ Ibid.

⁴⁸⁰Otiashvili,D., Kirtadze, I., O'Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2013). "Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers." *International Journal of Drug Policy*, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>

⁴⁸¹ Ibid.

According to this study, women felt that medical staff held them in contempt and showed an aggressive attitude towards them, regarding them as violators of socio-cultural norms. The lack of support and sympathy in treatment facilities, as well as judgmental medical personnel, are among the issues hindering women from engaging in treatment. The authors of the study noted that even women who have not been treated unfairly by medical staff are of the same opinion. It is noteworthy that the negative attitude of medical personnel was named as a main barrier for women in starting treatment. From the conclusions drawn by the authors of the study we can see that the fear of being stigmatized experienced by substance using women is not ungrounded. The authors of the study explain that the treating personnel are not free from traditional stereotypes. Most treatment services did not fully understand the needs of women, were not sufficiently aware of the fact that the disease progresses differently in men and women, and did not know how to provide women-oriented counseling. For example, service providers believed that unlike men drug-dependent women have a more severe clinical profile, are less likely to respond to treatment, and have a lower success rate.⁴⁸²

The fact that stigma is a major hindering factor for women seeking treatment is also evident from my interviews with women with substance use problems. As in the case of men, all of the interviewed women wanted to lead a healthy life. However, unlike men, their main motivating factor was children. Those women who have children noted that they wish for their children's well-being and did not want their children to be ashamed of their mothers.

The female respondents were concerned about the fact that society often expresses an aggressive attitude towards people with drug use problems, due to which their children also become victims of discrimination. The female respondents do not want society to talk about their children in a negative context. Another motivation and desire to recover is connected with health issues which were noted by male respondents too. Most of the women said that their health is increasingly deteriorating, and, at least for this reason, it is necessary that they quit drugs. They also want to live full lives and be able to reintegrate with society.

'Family and future, so that my child or grandchild will not be reminded that his/her mother drank or injected drugs. There have been many cases when a girl was prevented from creating a family because her parent or parents were drug users, or she was reminded of that after she had got married. For this

⁴⁸² Ibid.

reason, I try to live in a way that won't be shameful for my family and loved ones.' (R3, female, 27 years old, Gori)

'For the sake of my child, so that he is not embarrassed that his mother is a drug addict.' (R5, female, 39 years old, Gori)

'So that I can be honest with my loved ones, secondly, because I'm tired of so many problems. It is a problem for me, and I cannot call it otherwise. So that I can live a full life and perhaps even become worthy of a child. The main stimulus for me is to have a child and feel the warmth of motherhood. I need no other stimulus to quit drugs, if I manage to do it.' (R5, female, 33 years old, Zugdidi)

It should be noted that a large number of the women, as in the case of the men, have also resorted to self-treatment to quit drugs, while some (especially the respondents interviewed in Gori) directly switched to psychotropic substances. The majority of those women who have undergone detoxification were not hospitalized in a medical establishment the first time and transfusions in those cases were performed at home, while those who have applied to a medical facility say that they were hospitalized and underwent a detoxification course there secretly.

'At first, when I realized that I was in deep trouble and needed medical attention I made transfusions at home. Of course I did not tell the attending nurse the reason for the transfusions and lied to her that I was suffering from food poisoning and needed three transfusions. Yes, it helped me, in that; it cleansed my body, removed the intoxication and I was back on my feet again, but it did not remove the craving and I resumed taking drugs.' (R5, female, 32 years old, Tbilisi)

'I was in a clinic to get drug treatment; I was hospitalized there in secret as if my husband was there instead. I was registered with another person's name and surname. I didn't leave the room. Then I was hospitalized on Nutsubidze Street.' (R4, female, 30 years old, Tbilisi)

When asked about the reasons for undergoing detoxification at home, or concealing their true identity at a medical facility, most of the women named stigma. They said that in addition to the fear of being rejected by society, they did not trust that medical facilities would protect their anonymity. This answer is similar to the results of the study by Otiashvili et al. (2003) in which women respondents noted that they have never trusted and most of them do not trust medical staff even now and are afraid that they will be discriminated against by them.

'At first I was afraid and even now I am afraid. I know that they hate us. No matter how good doctors may be, they still can't hide aggression towards women like us. I don't want anybody to insult me

more. I have suffered enough and would rather treat myself than apply for help and hope to get assistance from people who despise me.’ (R5, female, 32 years old, Tbilisi)

‘I am afraid that my anonymity won’t be protected. Gori is a small town, everybody knows each other. At the medical facility I will definitely meet an acquaintance; a doctor, a nurse, and I doubt that they will resist the temptation of telling their loved ones about me, who in turn will tell others my story, and subsequently the whole town will know about it...’ (R1, female, 26 years old, Gori)

Women who have never applied to any treatment facility believe that self-treatment is the best option.

‘Self-treatment... You should take care of yourself; this is the best method... I drank pills and they helped me a lot; I took Tramal and Genazepam together.’(R3, female, 27 years old, Gori)

‘Because you would be humiliated if you went somewhere; they would reproach you. They would ostracize you from society because you are a woman. For this reason, I have not been anywhere. With the help of friends, with transfusions. It was again my friends who helped me; they brought me some ampules, and I treated myself at home.’ (R7, female, 40 years old, Zugdidi)

The first difference between the conditions of men and women is related to the fear of stigma. As I noted above, stigma as a barrier to treatment, was mentioned by male respondents only at the end of the conversation, and then only by four respondents. The majority of men cited financial problems and high cost of treatment services as major reasons for not engaging in treatment. Women, on the other hand, mentioned problems related to stigma; the fear that they will be ostracized by society, that their children will be discriminated against, and that even doctors will treat them badly.

It was widely discussed in previous chapters that substance use among females is more highly stigmatized than among males,⁴⁸³ and that social stigma, labeling, and guilt are significant barriers for females to receiving treatment.⁴⁸⁴ Stigma and stigma-related problems are of a social and cultural nature. Therefore, women who use drugs feel shame and guilt and see that they have failed to fulfill the expectations of society which makes it difficult for them to acknowledge substance use and engage in treatment. These feelings may be even greater for mothers or mothers-to-be who, as studies suggest, fear that they will be considered unfit to mother and will lose custody of their children.⁴⁸⁵

⁴⁸³ Grella, C. E., & Joshi, V.(1999). “Gender differences in drug treatment careers among clients in the national Drug Abuse Treatment Outcome Study,” *American Journal of Drug and Alcohol Abuse*, 25, pp.385-406.

⁴⁸⁴ Ayyagari, S., Boles, S., Johnson, P., & Kleber, H. (1999). “Difficulties in recruiting pregnant substance abusing women into treatment: Problems encountered during the Cocaine Alternative Treatment Study,” *Abstract Book Association for Health Services Research*, 16, pp. 80-81.

⁴⁸⁵ Brady, T.M. and Ashley, O.S.(2005). “Women in substance abuse treatment: Results from

Consequently, as women have a lot to lose, and have little faith that treatment facilities will protect their anonymity, they try to avoid treatment. From the above it is clear that, unlike men, who face mainly structural barriers to treatment, women are confronted with an insurmountable and crucial problem in the form of social and cultural factors, i.e. disproportionate stigma and discrimination. However, both men and women respondents have similar views concerning the treatment services in Georgia, claiming them ineffective, very expensive and lacking psychological rehabilitation.

'I was supposed to pay GEL 1,400 (636 EUR) in order to be hospitalized here for a week. I don't have so much money. The state gives me GEL 30 (13 EUR). Although no one has explained to me how I'm supposed to subsist on it, I do survive. I don't know how I have survived till now. But the fact remains that I'm alive. I'm not alone in this situation; there are quite a lot of us. I will only start receiving a pension after two and a half years. What should I do?' (R12, female, 57 years old, Tbilisi)

'No attention is paid to psychological factors whatsoever. How can one expect to be cured after the removal of just withdrawal symptoms? It is obvious that it's not possibly. Psychological consultations, rehabilitation, basic advice should be available, so that somebody can help you.' (R9, female, 27 years old, Tbilisi)

As in the case of men, women appeared to have insufficient information on substitution therapy and described this program in very critical and negative terms. Like the male respondents, women also characterized the methadone treatment in Georgia as ineffective and noted that patients of the program add certain medications to methadone. The women also expressed discontent over the lack of psychological rehabilitation during the substitution treatment.

'...that happens in Georgia, that they drink something and add something else to it and still end up being high on drugs. This is not realistic, it doesn't work. A lot of people have died here; they should have acted differently.' (R10, female, 35 years old, Tbilisi)

'It's not just about going [to the treatment facility] and taking your daily dose and going back home. Sometimes you need to talk to someone, you have questions and you don't know who to apply to. Talk and consultations are very important, there should be someone to talk to after taking your daily dose of medicine and not just rush back home.' (R8, female, 22 years old, Tbilisi)

'You go and take some medicine. If you want to talk to the doctor, you are not given the opportunity. They come and go every moment. I dislike it very much. We need psychological rehabilitation. Such a system has yet to be created.' (R9, female, 27 years old, Tbilisi)

Women respondents, like men, stress the importance of occupational therapy and believe that in the case of drug addiction, occupational therapy may have positive results. They also express the desire to receive trainings from treatment facilities to develop their professional skills. Such trainings would facilitate the recovery, raise self-esteem, and assist recovered individuals in finding a job in the future.

'Occupational therapy is very good. I've always thought that in the course of treatment it is crucial to get your mind off thoughts about drugs, to become occupied with something; and another key thing is the motivation to recover and start a normal life. Yes, you need a job for this, but who would hire a drug-addict? Therefore, there should be some vocational training that will develop your skills, give you knowledge, and increase your chances of employment after the treatment.' (R2, female, 29 years old, Gori)

Conversations with female respondents separated structural barriers (difficult access to treatment services, limited nature of services, lack of psychological consultations, etc.) from socio-cultural barriers – fear of stigma and discrimination. In the treatment system men encounter many structural problems, which is evident in their interviews, but when talking to women it became obvious that even with regard to structural barriers women come across many more serious impediments than men do. This fact indicates that women, unlike men, face both socio-cultural and structural barriers and thus find it more challenging to get engaged in treatment.

For example **lack of child care** is first in the list of structural barriers preventing women from accessing treatment. This list has been prepared by the United Nations Office on Drugs and Crime (2004).⁴⁸⁶ Unlike men, women who seek treatment usually have to take care of children; they have to solve issues concerning the well-being of their children.⁴⁸⁷ Women who want to engage in treatment often say that they have the responsibility to care for children, and unless there are easily accessible child care services, they will not be able to start treatment⁴⁸⁸ and women with substance use problems

⁴⁸⁶United Nations Office on Drugs and Crime (2004). "Substance abuse treatment and care for women: Case studies and lessons learned." Available at: https://www.unodc.org/docs/treatment/Case_Studies_E.pdf, Accessed: 5.12.13.

⁴⁸⁷Wong, C. J., Badger, G. J., Sigmon, S. C., & Higgins, S. T.(2002). "Examining possible gender differences among cocaine-dependent outpatients," *Experimental and Clinical Psychopharmacology*, 10, pp. 316-323.

⁴⁸⁸van Olphen, J., & Freudenberg, N. (2004). "Harlem service providers' perceptions of the impact of municipal policies on their clients with substance use problems", *Journal of Urban Health*, 81,

often believe that many treatment programs do not provide such services.⁴⁸⁹ The literature suggests that the fact that there is no facility for women to leave their children for care while they are in treatment is the most common reason hindering women from seeking treatment.

The respondents in my study who have children also mentioned the problems associated with child care during treatment. Most of them said that women are mostly responsible for the care of children and if a medical facility would in any way assist in caring for children this would be very helpful. Some of the women even noted that there is no waiting area for children in treatment facilities in Georgia, let alone child care services, which makes it difficult for women to use treatment services. In most cases women have nobody to leave their children with when they visit a medical facility for treatment or consultations. The respondents engaged in the Methadone Program even said that if there were a waiting room for children in the clinic where they go every day, it would make it easier for them to undergo methadone procedures.

'It is very difficult for a woman with a child to be in treatment. Where are you going to leave your child every time you visit the treatment facility? Therefore, there must be some child care services at that facility, for example, when you stand in line for methadone your child should not be standing by your side; he/she should be in a separate room for children, where he/she can play and not realize that his/her mother is a drug addict.' (R10, female, 35 years old, Tbilisi)

'I do everything for my children; I am a very good mother- everything that any ordinary mother would do. But what about those who can't? Who are too ill because of drugs to care for their children? Aren't their children at a disadvantage, in trouble..? Treatment facilities should think about such children.' (R4, female, 30 years old, Tbilisi)

Another significant barrier cited by the United Nations Office on Drugs and Crime (2004) is **services for pregnant women**.⁴⁹⁰ The United Nations Office on Drugs and Crime (2004) notes that in some countries it is illegal for a pregnant woman to abuse drugs in the course of pregnancy and such woman may be jailed for the duration of the pregnancy and lactation. In other countries, child welfare agencies may consider that substance use problems are equal to child abuse or neglect. Such policies prevent

pp. 222-231.

⁴⁸⁹ Nelson-Zlupko, L., Kauffman, E., & Dore, M. M. (1995). "Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women," *Social Work*, 40, pp. 45-54.

⁴⁹⁰ United Nations Office on Drugs and Crime (2004), "Substance abuse treatment and care for women: Case studies and lessons learned." Available at: https://www.unodc.org/docs/treatment/Case_Studies_E.pdf, Accessed: 5.12.13.

drug-dependent mothers from seek pregnancy follow-up resulting in grave consequences for the mother, foetus and society. Many studies on substance abuse treatment show that pregnancy and childbearing are significant events that may hinder women from engaging in and completing treatment.⁴⁹¹ Women with drug dependence are afraid of losing custody of their children if they start treatment due to the fact there have been cases where mothers using drugs during pregnancy were prosecuted for child abuse, delivery of drugs to a minor, and other charges.⁴⁹²

None of my respondents mentioned the need for special services for pregnant women. Female-oriented talk went without focusing on pregnant drug-dependent women. However, we can conclude from the conducted interviews that my respondents have very scarce information on treating drug addiction during pregnancy and on ways to solve this problem. Most of the women who were not yet mothers at the time of the interview and were potential mothers believed that they would bear unhealthy children if they used drugs. This makes it obvious that women should be provided more information on the abuse of drugs during pregnancy, on the correct measures aimed at quitting drugs during pregnancy, It should also be taken into account that many drug-dependent women in Georgia do not consult gynecologists, let alone treat drug dependence, or they hide their substance abuse from gynecologists, which can result in tragic consequences.

The third and fourth structural barriers listed by the United Nations Office on Drugs and Crime (2004) are the **cost of treatment and strict programme schedules**.⁴⁹³ Similarly to men, women are also concerned about expensive treatment services, and this high cost turned out to be the major reason for men refusing to seek treatment. As the United Nations Office on Drugs and Crime (2004) explains, there are a number of social and cultural factors that prevent women from seeking treatment in rehabilitation centers. These factors include women's inability to leave their neighborhoods, their responsibilities as mothers and housewives, and lack of transportation or money to get to centers and to undergo treatment. Women may also find it difficult to engage in outpatient programmes that are far from where they live, even if they are located in the same city. Apart from the high cost of treatment, women's family and household responsibilities may prevent them from attending programmes with

⁴⁹¹ Ayyagari, S., Boles, S., Johnson, P., & Kleber, H. (1999). "Difficulties in recruiting pregnant substance abusing women into treatment: Problems encountered during the Cocaine Alternative Treatment Study." *Abstract Book Association for Health Services Research*, 16, pp. 80-81.

⁴⁹² Chavkin, W., Breitbart, V., Elman, D., & Wise, P. H. (1998). "National survey of the states: Policies and practices regarding drug-using pregnant women," *American Journal of Public Health*, 88, pp. 117-119. Erratum in 88, 438, and 88, 820. Comment in 88(1), pp. 9-11.

⁴⁹³ United Nations Office on Drugs and Crime (2004), "Substance abuse treatment and care for women: Case studies and lessons learned." Available at: https://www.unodc.org/docs/treatment/Case_Studies_E.pdf, Accessed: 5.12.13.

fixed schedules. Therefore, it would be better if programmes had flexible schedules. Research shows that women involved in opioid maintenance treatment and having to visit the clinic every day find it difficult to keep up with limited program hours (e.g. not open in the evenings), as well as to observe the rules regarding take-away doses. Many programs are in fixed locations and do not provide outreach.⁴⁹⁴

Female respondents talked extensively about the high cost of treatment. Like the men, they also noted that treatment is very expensive in Georgia and that they cannot afford to pay so much. In particular, women are in a more difficult position because treatment programs do not take into account the specific needs of women, and fear of stigma and social rejection are also added to the mix.

'It's very expensive. How can I get so much money? Even if I had this kind of money, I would not waste it. I need psychological assistance rather than transfusions, and if I go to treatment center, who would look after my home and affairs, family, who would make dinner? And even if I manage to do that, I don't believe that the next day the whole town wouldn't know about my addiction. I know that I would not be received with warmth there. They would treat me like a wretched person, so why should I waste my money?' (R4, female, 30 years old, Zugdidi)

Another structural barrier cited as crucial by the United Nations Office on Drugs and Crime (2004) is **physical safety**.⁴⁹⁵ For all women, but particularly for those who have experienced physical or sexual abuse or whose current lives are extremely vulnerable to violence (e.g. women engaged in sex work), lack of physical safety inside and outside the treatment programme setting can be a barrier to entering and remaining in treatment. Lack of physical safety is one of the principle problems which Georgian women face in treatment facilities. Both experts and male respondents said that aggression towards women drug users is high. They also recalled cases when a man attacked a woman in a treatment facility (see Chapter 4 and the beginning of 5). Women respondents were also concerned about the fact that men and women are not separated in treatment facilities, which made women feel insecure. The female respondents who were involved in the rehabilitation process at the time of the interview noted that men and women undergo treatment in the same area, which creates a problem for women. Despite the fact that some centers have separate entrances for men and women, the existing system fails to ensure anonymity for women and, for this reason, a number of women avoid involvement in the Methadone Program. The female respondents also noted that there have been a number of cases when

⁴⁹⁴ Ibid.

⁴⁹⁵ Ibid.

the staff reproached female drug users. They also talked about abusive verbal comments about women with drug use problems from staff members.

'I know of many women who are embarrassed about taking treatment together with men and say that they would come if there were a separate area for women. They don't want to receive treatment together with men.' (R6, female, 41 years old, Tbilisi)

'We visited an NGO. We entered a room and, as we were women, we sat in the corner for a while. A young handsome guy who looked like a model entered the room; he said he was a drug user and wanted to talk with an expert. After a while, the psychologist came in and they asked her about the patient. She said he was a very handsome guy and it was a pity he did this. There were two more girls before me. A little time after one of the girls had entered the psychologist's room; the psychologist came out and said: 'What a fool! She has a good family, husband, and children; everyone helps her, and she is well-off. She is a fool. I have no idea why women need this.' This is what I saw with my own eyes; they took pity on a man and didn't reproach him; they even said he was handsome. But they judged the woman and said she was a fool and said very bad things about her. Those were medical staff specializing in this field; they had arrived from Tbilisi.'

 (R2, female, 34 years old, Zugdidi)

'No, they should not be together... when a man sees a woman there, he will insult her afterwards. After you recover and are discharged from the hospital, people will see you in the street and say that you were getting treatment together with them. For this reason, I think it should be a closed space to ensure that no one can see a woman there and she will be protected. In spite of everything, it is her past and she doesn't want to remember it. No one should remind her of that. She may have a long life ahead.' (R11, female, 34 years old, Tbilisi)

'It should be divided into a men's block and women's block.' (R2, female, 24 years old, Tbilisi)

Apart from physical insecurity two more important problems have been revealed that correspond to the structural barriers listed by the United Nations Office on Drugs and Crime (2004). The first problem is connected with **coordination of services**.⁴⁹⁶ Several respondents described during the interviews the situation where besides drug dependence they suffered from family violence and did not know where or how to seek help. Respondents cannot associate this problem with the improper functioning of treatment system, however the situations described by them are directly connected with the lack of coordination of clients' different needs and system malfunctioning.

⁴⁹⁶ Ibid.

'One day my husband beat me brutally and forbade to leave home, although I was involved in treatment at that time, had been going for some time and was about to quit drugs. I don't know, maybe he found out I was hiding it from him and got angry, I had bruises, felt very bad and did not know what to do or who to turn to. Of course I couldn't attend treatment that day. I went there a few days later, just a couple of visits and that's it. But I needed consultation, needed to tell somebody about my problems with domestic violence, about my fear of him, but there was nobody to talk to. There was no psychotherapist and I didn't want to tell my problems to other girls.' (R5, female, 32 years old, Tbilisi)

People with substance use problems usually need various medical and social services. If the major systems are not coordinated properly it creates barriers to meeting the needs of drug-dependent individuals.⁴⁹⁷ In the case of women, it is imperative that the work of the treatment system, the child welfare system, the prenatal-care system, and the violence protection system is coordinated. One of the crucial structural gaps in the case of drug-dependent women is related to violence, which was reviewed in detail in Chapter 4. The interviews conducted with experts have shown that drug abuse treatment services neglect family violence, and vice versa, that domestic violence prevention services do not take into consideration the needs of women with substance use problems (see Chapter 4). Therefore, the fact that treatment of drug dependence does not include such crucial services as child care services, special services for pregnant women or for victims of domestic violence, and that women's needs are not coordinated within these systems, points to the improper functioning of the system and creates yet another barrier. And the reasons for failure of coordination between systems are often related to different views regarding substance use problems, the kind of services a client needs, and different policies and procedures regarding confidentiality.

Another problem representing a structural barrier, not mentioned by my respondents, is related to treatment services, in particular the **lack of information**.⁴⁹⁸ The United Nations Office on Drugs and Crime (2004) states that helping professionals, as well as women and their families, often do not have information on available treatment options. According to Otiashvili et al. (2013) the vast majority of health service providers in Georgia was unaware of specific types of substance-use-treatment opportunities in their city, and did not seek connections with other service providers, indicating absence of links between substance-use and other services. When talking about difficulties and deficiencies related to treatment, the respondents did not mention the lack of information as one of the deficiencies

⁴⁹⁷ Ibid.

⁴⁹⁸ Ibid.

of the system, but from their conversations it is clear that they get information not directly but through various acquaintances. It is also clear that they have inaccurate information, especially regarding methadone, which points to the necessity on the part of treatment facilities to ensure accurate and proper provision of information.

'In spite of everything, methadone is a narcotic substance and, one way or another, they (drug users) are still dependent on it. Whichever establishment a person goes to with the aim of removing drug dependence, it is not enough to remove physical dependence alone.' (R6, female, 36 years old, Zugdidi)

'I'd rather be the way I am now than be killed by methadone. Everybody knows that methadone is a last-ditch solution for those who have no chance. They have them drink it, silence them, and are happy.' (R5, female, 39 years old, Gori)

Interviews with both male and female respondents have shown that they face many serious problems and barriers during treatment. These problems are gender-specific, however, there are also many similar factors. For the purpose of improving drug dependence treatment services in Georgia and making them more client-oriented, the problems listed above must be taken into account and ways of solving those problems must be found.

Conclusion and recommendation for successful model of treatment from a gender perspective

This chapter demonstrates that there are many problems and barriers during drug treatment entry which have a negative effect on the choice and motivation of individuals to use treatment services.

Both men and women have similar views concerning treatment services in Georgia. They assess it as ineffective, very expensive, and lacking many components like psychological rehabilitation, vocational training, and occupational therapy- all of which are of immense importance in order to have a positive outcome from the treatment.

This chapter demonstrates that it is difficult for the respondents of both genders to obtain money for treatment, and most of them express the wish for a price decrease. Therefore, one of the steps to be taken towards making treatment accessible is the reduction of the current price and some kind of contribution on the part of the state, so that more people can enjoy state funding during treatment ultimately resulting in the involvement of more people in the treatment process.

The next option in order to improve the situation is connected with the **duration of treatment**. Both male and female respondents said that treatment is very short and is focused solely on removing

physical dependence. Therefore, extension of the treatment period and enhancing psycho-rehabilitation component will significantly improve the treatment process and will be more oriented towards client needs.

The next stage in improving treatment services is related to diversity of treatment services. As my respondent pointed out, the treatment process must engage individuals with drug use problems in some sort of activity, so that they divert their attention to other activities and learn a particular trade which will help them find new strength within themselves. Most of the respondents mentioned the importance of occupational therapy and expressed the desire to be involved in vocational trainings during the treatment. Accordingly, I think it is important to take into consideration that the development of occupational therapy programs and vocational training programs during treatment may increase the effectiveness of rehabilitation of clients and serve as motivation for recovery.

The above stages aimed at improving treatment services are similar for both genders. However, as I already mentioned, and as is confirmed by my interviews, women are in a more disadvantaged position than men in terms of problems and barriers associated with treatment. Apart from the similar problems listed above, pointing to the structural deficiencies of the system, there are also a number of additional structural barriers that only women encounter because of their gender.

The interviews with the respondents outline that women encounter not only structural but also socio-cultural barriers which hinder their entry into treatment or lower their motivation to use treatment services. The most critical structural barriers for women are lack of childcare resources, safety concerns, lack of knowledge about available treatment options, as well as lack of coordination between substance abuse treatment services and other women-oriented services.

Special consideration should be given to the fact that women are requesting separate rehabilitation centers, which will at least solve the problem of physical insecurity. Apart from the above structural barriers, unlike men, women also encounter cultural and social problems. The social, cultural and personal barriers to treatment which women experience include a significant stigma and shame and guilt associated with substance use and related problems among women - fear of losing custody of children, lack of support from the partner and from the family to start treatment, as well as a lack of trust in treatment.

Therefore, we get a picture where, in order to properly plan and implement women-oriented treatment services, structural barriers should be taken into account based on the needs of women. Treatment facilities should have a qualified staff that is well aware of the fact that those social and cultural

problems associated with women come from social and gender bias, a fact that should be taken into account during treatment.

Chapter 7

Conclusion

The general aims of the proposed dissertation were to explore the gender differences in the cases of Georgian men and women with substance use problems and to identify what kind of social and psychological problems and barriers Georgian men and women with substance use problems encounter in everyday life and during treatment. Examining the issues from a gender perspective, the study demonstrated that there is a big difference between drug-dependent men and women in Georgia. And most importantly, this difference is not conditioned solely by biological factors. There are a number of social and cultural factors at play placing women in a much more difficult and vulnerable situation than men. 20 drug experts and 52 individuals with drug use problems participated in this study. The qualitative interviews conducted with the above persons clearly demonstrate that both male and females with drug use problems encounter a lot of stigma which negatively affects them.

The study shows that stigma, its effects, and responses to it, are those significant issues where the fundamental difference between men and women with substance use problems are most evident. Stigma is encountered at all stages of drug abuse. Once society learns that a certain individual is using drugs, that individual is automatically stigmatized and this fact impacts both further abuse of substances and the defense strategy used by the person. The stigma plays a large part in the treatment process and at every stage in life.

The study also reveals that the stigma against individuals who use drugs is too often aimed at the individual as opposed to the behavior itself. When analyzing the comments made by the participants of this study it became clear that stigma can affect them in two ways – make them hide their addiction problem and continue to use, or motivate them to modify their drug use behaviour - switch to psychotropic drugs. Yet it was also noted that the latter is extremely difficult due to the present stigma acting as a barrier. The problem of being ostracized from the rest of society is common and relevant to both males and females with drug use problems. This problem is manifested not only in the verbal or non-verbal behavior of society, but also in such issues as full membership in society, employment, and

the ability to support oneself financially. Yet society does not trust these people, regardless of whether they are currently using drugs or have quit drugs and are involved in the treatment process. In addition, society is not interested in the opinions of these people and does not consider their professional qualifications as adequate.

During the interviews individuals who have drug use problems spoke about the negative effects of stigma on their self-perception; they develop low self-esteem. Social values and society's responses force them to deprecate themselves. It is also obvious from the interviews that stigma adversely affects the respondents' family members and their loved ones.

The study has established that, in terms of the negative effects of the stigma, women are in a more unfavorable and difficult position than men and this is related to patriarchal views and cultural values. Women are considered by Georgian society to be the guardians of family norms and values, their principal purpose in life to care for their families and bear children. Therefore, the behavior of the women who use substances is perceived as deviant, because they do not adhere to the widely accepted social norms. For this reason substance using women are described as individuals who lack will or principles, and are reckless or careless. A woman with drug addiction is considered a bad person, deviant, more serious, and more wrong in the sense that she has 'transgressed against the social norms of being a good woman.' The study makes it evident that a woman who abuses substances is not perceived as a nurturer and caretaker, and if she has children she is perceived as a bad mother and it is widely believed that she cannot and must not raise children. This extremely negative and intolerant attitude is clear not only from the interviews with male respondents but also from the interviews with female respondents. The women, both in respect of themselves and other women, fully share the view that they have breached the principal norms established for women, and, therefore, they do not deserve respect.

The negative impact of stigma is also evident in the fact that, according to the interviews, women suffered rejection from more people than men did. Women were ostracized by parents, family members, and friends, while men seldom experienced such rejection. In most cases families stood by them all the time.

Furthermore, the negative effect of stigma is more profound in the case of family members of women drug users. The study demonstrates that, unlike men, women are more ashamed of drug abuse; their family members are even more embarrassed and desperately try to hide the fact; and all this is due to rejection and criticism from society which is far more powerful in respect of women than men.

According to the study, the respondents believe that substance abuse is more permissible for men than for women, and, therefore, women have to be punished more severely.

The study demonstrates that women are rejected not only by their families and society, but also by other substance abusing women, as well as experiencing violence and aggression from male drug users. The study also shows that drug experts, as well as doctors treating drug dependence, have a stereotyped attitude towards females with drug use problems and view their problems and drug related disorders through the lens of biological determinism, while disregarding socio-cultural factors.

Negative, stigmatized attitude of attending physicians, society and male drug users has grave impact on women in terms of their self-perception, self-esteem and the motivation to recover, which is manifested in the fear and lack of confidence in medical staff.

On the basis of this study we can single out two additional issues where there are major differences between men and women – reasons for drug use and treatment process. From the analysis that the study offers on these two matters, we reach the conclusion that both are related to one principal issue – understanding the roles and rights of women.

In the case of my male respondents the reason for drug use is directly linked to their peer group and conformist behavior. Most of them tasted drugs at the age of 13-15, before they finished school. Based on the interviews it can be safely assumed that one of the major factors triggering their interest in drugs was the criminal mentality of the 90s, the incorrect attitude to drugs, and the easy access to them. The situation is different in the case of women respondents. Although they cite their desire and interest as the main reasons for their tasting drugs, the reasons for continuous and systematic use are different. These reasons are not related to external factors, interest or social circle; they are more connected with the desire to overcome and forget psychological problems.

As opposed to men who blamed external factors for their drug use, in the case of women it is the family, spouses, and situations related to personal psychological problems which appeared to be the main motivation to use drugs and escape from reality. This is especially true for the women from regions (Zugdidi and Gori). They acknowledged that severe psychological terror in the family, continuous insults from their husbands, lack of love and peace, and absence of support and stability were so depressing that they chose drugs as the preferred means of escape. Therefore, a fundamental difference is obvious – although interest may be the first reason for tasting drugs in both cases, in the event of repeated and systematic drug use the reasons diverge; while men use drugs repeatedly for

more pleasure and self realization, women are trying to escape from their subordinated, oppressed and traumatic situations.

Another significant motivator with respect to the difference between women's and men's drug use is the initiative on the part of men to offer drugs to their partners/spouses. A seemingly banal desire to make their partners experience the positive side of intoxication ultimately becomes a means of gaining more control over women and keeping them in a more subordinated and oppressed state. The drug abusing partner affects not only women's drug abuse, but also their treatment process, because remaining in unhealthy relationships means receiving less support in the recovery process.

The second major difference between males and females with drug dependence revealed during the study is related to treatment. This study demonstrates that, in general, treatment services are not tailored either to the needs of men or to those of women and require serious improvement. One of the principal problems encountered by both men and women is the difficult access to treatment, and high costs, preventing them from seeking treatment. Another serious problem faced by the representatives of both genders is the limited duration and content of the treatment process. The treatment is so short that it is not sufficient to yield positive results and it is aimed only at removing physical dependence on drugs and does not include either psychological rehabilitation or other activities, such as occupational therapy, rehabilitation, etc.

The above deficiencies point to the improper structural operation of the treatment system. However, there are a number of structural barriers encountered by women because of their gender. Particularly critical barriers for women are lack of childcare resources, program location, safety concerns, lack of knowledge about available treatment options, and lack of coordination between substance abuse treatment services and other women-oriented services.

Special attention should be given to the fact that women are requesting separate, independent facilities from men and believe that such rehabilitation facilities would at least solve the problem of physical insecurity. Apart from the listed structural barriers, women, unlike men, experience additional problems of a cultural and social nature. The social, cultural, as well as personal barriers to treatment entry which women experience include the significant stigma and shame and guilt associated with substance use and its related problems among women: fear of losing custody of children, lack of support from partner and family to go to treatment, and lack of confidence in treatment. Due to stigma and the associated problems, women, unlike men, are more rejected and oppressed, and this factor plays a major part in the case of women who refuse to engage in treatment. For fear of losing their

social status, children and family members, women do not seek treatment, because they do not believe that their anonymity will be protected in the treatment facility or that the medical personnel will provide the appropriate assistance. The anticipation of fear of being rejected and abused by medical staff is one of the major internal barriers for women during treatment. Although personnel and counselors can help women tackle and overcome personal barriers to treatment (such as issues of motivation and shame), programming and administrative policies do not address obstacles surrounding program structure, interagency coordination, and service delivery and this results in a big structural problem for women in treatment. The fact that other problems associated with drug dependence are not taken into account is one of the specific problems for women during treatment. These problems are related to mental health and family violence. Statistical data suggest that 80 percent of drug-dependent women are victims of violence in Georgia,⁴⁹⁹ and this study shows that the women-oriented treatment services do not acknowledge the importance of considering the impact of domestic abuse on delivering treatment that is effective, accessible and meets the needs of female service users.

It is evident, based on the interviews with study respondents, that substance abuse professionals are rarely aware of the complicated issues that women bring into treatment with them. Facilitators in the process of recovery, who are aware of the substance abuse itself, mostly ignore the presence of other mental disorders that are prevalent among women who use substances.

This study has shed light on the different reasons for drug use in men and women and has highlighted the psychosocial barriers aggravating their situation and hampering treatment. The information obtained during the interviews is useful in terms of improving the treatment process and developing preventive activities. In addition, it demonstrates the significance of analyzing the substance abuse problem from a gender and feminist perspective in order to bring to the forefront the problems associated with women in particular, and to look for solutions in a gender sensitive context.

This study makes it obvious that women who are undergoing treatment for drug dependence have specific needs and that treatment facilities should take into account these needs, as well as possible barriers, in order to keep female patients in treatment and achieve positive results. Hopefully, this study will contribute to the improvement of the treatment services in Georgia and facilitate further research aimed at the betterment of the lives of individuals with substance use problems.

⁴⁹⁹ Harm Reduction International (2013). "Violence against Women who use Drugs, and Access to Domestic Violence Shelters." Briefing Paper. Available at: http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03.13_.pdf, Accessed: 17.12.13.

Bibliography

1. Acker, C. J. (1993). "Stigma or Legitimation? A Historical Examination of the Social Potentials of Addiction Disease Models," *Journal of Psychoactive Drugs*, 25(3), pp. 193-205.
2. Ahern J, Stuber J, Galea S. (2007). "Stigma, discrimination and the health of illicit drug users," *Drug Alcohol Depend*, 88, pp. 188–96.
3. Akers, R. L. (1998). "*Social learning and social structure: A general theory of crime and deviance.*" Boston, MA: Northeastern University Press.
4. Anderson, T. L. (2001). "*Drug Use and Gender.*" Encyclopedia of Criminology and Deviant Behavior, Vol. IV: Self-Destructive Behavior and Devalued Identity, pp. 286-289.
5. Anderson, T.L. and Ripullo, F. (1996). "Social Setting, Stigma Management, and Recovering Drug Addicts," *Humanity & Society*, 20(3), pp. 26-43, 36.
6. Anspach, R. (1979). "From Stigma to Identity Politics: Political Activism among the Physically Disabled and Former Mental Patients," *Social Science and Medicine*, 13(A), pp. 350-363.
7. Aramburu, B., Leigh, B. (1991) "For better or worse: Attributions about Drunken Aggression toward Male and Female Victims," *Violence and Victims*, 6(1), pp. 31–42.
8. Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). "Effectiveness of substance abuse treatment programming for women: a review," *American Journal of Drug and Alcohol Abuse*, 29, pp. 19-35.
9. Ataiants, J., Merkinaitė, S., Ocheret, D. (2012) Policing people who inject drugs: Evidence from Eurasia, Available at: http://www.harm-reduction.org/sites/default/files/pdf/IDPC-briefing-paper_Policing-people-who-inject-drugs-evidence-from-Eurasia.pdf, Accessed: 15.10.2013.
10. Atkinson, R. and Flint, J. (2001). Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies, Available at: <http://sru.soc.surrey.ac.uk/SRU33.html>, Accessed: 18.10.13.
11. Avis, J. M. (1988). *Deepening awareness: A private study guide to feminism and family therapy*. In L. Braverman (Ed.), *Women, feminism, and family therapy* (pp. 15-46). New York: Haworth Press.
12. Ayyagari, S., Boles, S., Johnson, P., & Kleber, H. (1999). "Difficulties in recruiting pregnant substance abusing women into treatment: Problems encountered during the Cocaine Alternative Treatment Study." *Abstract Book Association for Health Services Research*, 16, pp. 80-81.
13. Bandura, A. (1977). "Social Learning Theory." General Learning Press.

14. Beaumont, B. (2004). *"Care of Drug Users in General Practice: A Harm Reduction Approach."* Oxford: Radcliffe Publishing.
15. Bennet, E. M., & Kemper, K. J. (1994). "Is abuse during childhood a risk factor for developing substance abuse problems as an adult?" *Developmental and Behavioral Pediatrics*, 15 (6), pp.426-429.
16. Bennett, L.W. (1995). "Substance Abuse and the Domestic Assault of Women," *Social Work*, 40(6), pp. 760–772.
17. Ben-Yehuda, N. (1990). *"The Politics and Morality of Deviance: Moral Panics, Drug Abuse and Reversed Stigmatization."* Albany: State University of New York Press, pp. 66-67.
18. Bernadette Pelissier and Nicole Jones (2005). "A Review of Gender Differences among Substance Abusers," Available at: http://www.bop.gov/news/research_projects/published_reports/drug_treat/oregender_differences.pdf, Accessed: 2.03.13.
19. Binsardi, A. and Green, J. 2012. *'Research Methods for Management'*. Pedagogic Teaching Series, 2, London, UK, Publisher: Northwest Academic Publications (NAP)
20. Bloom, B., Covington, S. (1998). "Gender-Specific Programming for Female Offenders: What is it and Why is it Important?" Paper presented at the 50th annual meeting of the American Society of Criminology. Available at: <http://www.stephaniecovington.com/pdfs/13.pdf>, Accessed: 27. 04. 2012.
21. Boyd, S. C. (1999). *"Mothers and Illicit Drugs: Transcending the Myths."* Toronto: University of Toronto Press.
22. Boyd, C., Blow, F., Orgain, L. S. (1993). "Gender Differences among African-American Substance Abusers," *Journal of Psychoactive Drugs*, 25(4), pp. 301-305.
23. Brady, T.M. and Ashley, O.S. (2005). "Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS)." Available at: <http://www.samhsa.gov/data/womentx/womentx.pdf>, Accessed: 20.02.14.
24. Bride, B.E. (2001). "Single-Gender Treatment of Substance Abuse: Effect on Treatment Retention and Completion," *Social Work Research*, 25(4), pp. 223-232.
25. "Briefing on Substance Use Treatment and Recovery in the United States," (Executive Summary). Available at: http://partnersforrecovery.samhsa.gov/docs/Briefing_Substance_Use_Treatment.pdf, Accessed: 5.12.2013.

26. Brown, P. J. (2000). "Outcome in female patients with both substance use and post-traumatic stress disorders," *Alcohol Treatment Quarterly*, 18(3), pp. 127-135.
27. Brownfield, W.R. (2006). International Narcotics Control Strategy Report: Volume I: Drug and Chemical Control. Available at: <http://books.google.ge/books?id=0jnyNWFuhXYC&pg=PA289&lpg=PA289&dq=INCSR,+2006+Georgia&source=bl&ots=isn8Acb3MA&sig=taEWuZzjOy4j7ZKd5qi6lAfWoN0&hl=en&sa=X&ei=t8g9UfLpCMeiO7HqgIAB&ved=0CGYQ6AEwBg#v=onepage&q=INCSRpercent20Cpercent202006percent20Georgia&f=false>, Accessed: 11.03.2013.
28. Brownmiller, S. (1975) "*Against Our Will*." New York: Simon and Schuster, p. 5.
29. The Bureau of International Narcotics and Law Enforcement Affairs of the US Department of State, International Narcotics Control Strategy report of March 2004, Washington, <http://www.state.gov/j/inl/rls/nrcrpt/2003/vol1/html/29838.htm>, Accessed: July 2012.
30. Bryan, A., Moran, R., Farrell, E., O'Brien, M. (2000). "Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Survey," Dublin: The Health Research Board.
31. Canadian Women's Foundation (2011) "Report on Violence against Women, Mental Health and Substance Use." Available at: http://www.canadianwomen.org/sites/canadianwomen.org/files/PDFpercent20percent20VPpercent20Resourcespercent20percent20BCSTHpercent20CWFpercent20Report_Final_2011_percent20Mentalpercent20Health_Substancepercent20use.pdf, Accessed: 18.09.10
32. Center for Addiction and Mental Health (1999). "The Stigma of Substance Use: A Review of the Literature." Available at: http://www.camh.ca/en/education/Documents/www.camh.net/education/Resources_communities_organizations/stigma_subabuse_litreview99.pdf, Accessed: 8.08.2013.
33. Chandler, R.K., Fletcher, B.W., Volkow, N.D.(2009). "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety,"*The Journal of the American Medical Association*, 301(2), pp.183-190.
34. Chavkin, W., Breitbart, V., Elman, D., & Wise, P. H. (1998). "National survey of the states: Policies and practices regarding drug-using pregnant women," *American Journal of Public Health*, 88, pp. 117-119. Erratum in 88, 438 and 88, 820. Comment in 88(1), pp. 9-11.
35. Chesler, P. (2005) "*Women and Madness*". Palgrave Macmillan.

36. Chitashvili, M., Javakhishvili, N., Arutiunov, L., Tsuladze, L., Chachanidze, S. (2010), "National Research on Domestic Violence against Women in Georgia." Available at: <http://www.genderbasedviolence.ge/conimages/annual-eng.pdf> Accessed: 5.07.2013
37. Clarey, L. and Felstead, B. (1990), "The Contribution of Occupational Therapy to Alcohol and Drug Rehabilitation: A Descriptive Review," *Australian Occupational Therapy Journal*, 37, pp. 85–88.
38. Clark, W. (2001) "Violent Traumatic Events and Drug Abuse Severity," *Journal of Substance Abuse Treatment*, 20, pp. 121-127.
39. Common myths about rape. Available at: <http://www.rapecrisis.org.uk/commonmyths2.php>, Accessed: 25.09.13.
40. Copeland, J. (1997). "Barriers to Formal Treatment among Women who Self-Managed Change in Addictive Behaviors," *Journal of Substance Abuse Treatment*, 14 (2), pp.183, 183-190,186.
41. Corrigan P. (2000). "Mental health stigma as social attribution: implications for research methods and attitude change," *Clinical Psychology Science and Practice*, 7, pp. 48–67.
42. Corrigan, P.W. and Shapiro, J.R. (2006). "Blame, Shame, and Contamination: The Impact of Mental Illness and Drug Dependence Stigma on Family Members," *Journal of Family Psychology* 20 (2), pp. 239-46.
43. Corrigan, P.W., Amy C. Watson, Frederick E. Miller (2004). "Shame, Blame, and Contamination: A Review of the Impact of Mental Illness Stigma on Family Members." Manuscript submitted to *Psychological Bulletin*.
44. Corrigan, P.W., Kuwabara, S.A., O'Shaughnessy, J. (2009). "The Public Stigma of Mental Illness and Drug Addiction: Findings from a Stratified Random Sample," *Journal of Social Work*, 9 (2), pp. 139-47.
45. Crisp, A., Gelder, M., Goddard, E., Meltzer, H. (2005). "Stigmatization of people with mental illness: A follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists," *World Psychiatry*, 4 (2), pp. 106-13.
46. Crocker, J., Major, B., Steele, C. 1998. "Social stigma." *Handbook of Social Psychology*, ed. Fiske, S., Gilbert, D., Lindzey, G. vol. 2, pp. 504–53. Boston, MA: McGraw-Hill.
47. Dawson, D., Grant, B., Chou, S., Stinson, F. (2007). "The impact of partner alcohol problems on women's physical and mental health," *Journal of Studies on Alcohol and Drugs*, 68(1), pp. 66–75.
48. Decree No. 351 of the President of Georgia of June 4, 1999.

49. Dobash, R.E., Dobash, R. (1997) *“Violence against Wives.”* New York: Free Press, p. 237.
50. Drug Scope and AVA “The Challenge of Change: Improving services for women involved in prostitution and substance use.” Available at: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/Challengepercent20ofpercent20change_policypercent20briefing.pdf, Accessed: 19.12.13.
51. Durkheim, E. (1982). *“Rules of Sociological Method (1895).”* Free Press.
52. Ettore, E. (2004). “Revisioning Women and Drug Use: Gender Sensitivity, Embodiment and Reducing Harm.” Available at: <http://www.medanthro.net/adtsq/wp-content/uploads/2012/12/Ettore-Revisioning-Women-+-Drug-Use.pdf>, Accessed: 8.10.2013.
53. Ettore, E. (1992) *“Women and Substance Use.”* London: Macmillan, p.78.
54. Eurasian Harm Reduction Network. “Stigma and Discrimination.” Available at: <http://www.harm-reduction.org/stigma-discrimination.html>, Accessed: 5.12.2013.
55. European Monitoring Center for Drugs and Drug Addiction, Available at: <http://www.emcdda.europa.eu/publications/country-overviews/ge#gps>, Accessed: 10.07.2013.
56. European Values Study 2008 (EVS). Available at: <http://www.europeanvaluesstudy.eu/evs/data-and-downloads/>, Accessed: 11 February 2013.
57. Falk, G. (2001). *“Stigma: How We Treat Outsiders.”* Prometheus Books.
58. Finkelstein, N. (1994). “Treatment Issues for Alcohol and Drug-Dependent Pregnant and Parenting Women,” *Health and Social Work*, 19(1), pp. 7-15.
59. French, M.T.; Dennis, M.L.; McDougal, G.L.; Karuntzos, G.T.; and Hubbard, R.L. (1992) “Training and employment programs in methadone treatment: Client needs and desires,” *Journal of Substance Abuse Treatment*, 9 (4), pp. 293–303.
60. Frišaufová M. (2012). “The Female Drug User as a ‘Victim’ or ‘Villain’ and the Implications for Social Work,” *Social Work and Society*, 10(1). Available at: <http://www.socwork.net/sws/article/view/313/657>, Accessed: 11.09.13.
61. Fiske, S (1992). “Controlling other People. The Impact of Power on Stereotyping.” Available at: http://www.radford.edu/~jaspelme/private/gradsoc_articles/stereotypespercent20andpercent20prejudice/Power_and_stereotypes.pdf, Accessed: 17.12.13.
62. Galvani, S., Humphreys, C.(2007). “The Impact of Violence and Abuse on Engagement and Retention Rates for Women in Substance use Treatment.” Available

- at: http://www.nta.nhs.uk/uploads/nta_the_impact_of_violence_and_abuse_women.pdf, Accessed: 17.09.13.
63. Gamkrelidze, A., Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2003). "Drug Situation in Georgia – 2003." Tbilisi, Georgia: Southern Caucasus Anti-Drug Programme.
 64. Gamkrelidze, A., Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2005). "Drug Situation in Georgia – 2005." Tbilisi, Georgia: Southern Caucasus Anti-Drug Programme.
 65. Gatz, M., Russell, L.A., Grady, J., Kram-Fernandez, D., Clark, C., Marshall, B. (2005). "Women's Recollections of Victimization, Psychological Problems, and Substance Use," *Journal of Community Psychology*, 33(4), pp. 479-493.
 66. Georgian Harm Reduction Network (2008). "Shadow Report on the Drug Situation in Georgia for the Years 2006-2007," pp. 3-15.
 67. Gignac, S. (1999) "Substance Abuse and Women: a Comprehensive Qualitative Analysis of the Literature." Available at: https://www.google.ge/webhp?source=search_app&gws_rd=cr&ei=dgSPUpOOGcaY4gSTjIHABA#q=women+drug+users+reportedly+experience+sexual+harassment+from+counselors+percent2C+other+program+staffpercent2C+or+male+clients, Accessed: 22.11.13.
 68. Gilvarry, E. (2000). "Substance abuse in young people," *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 41, pp.55-80.
 69. Goffman, E. (1963). "*Stigma: Notes on the Management of a Spoiled Identity*." Englewood Cliffs: Prentice-Hall, Inc., pp. 2-3, 15, 18.
 70. Gomberg, E.S.L. (1982). "Historical and political perspective: Women and drug use," *Journal of Social Issues*, 38 (2), pp. 9-23.
 71. Goode, E. (1984). "*Deviant Behavior*" (Second Edition). Englewood Cliffs: Prentice-Hall, Inc., p. 35.
 72. Goode, E. (1989). *Drugs in American Society*". New York: McGraw-Hill Publishing.
 73. Goodman, L.A. (2011). On Respondent-Driven Sampling and Snowball Sampling in Hard-To-Reach Populations and Snowball Sampling Not in Hard-to-Reach Populations. In: Liao Tim Futing., Editor. *Sociological Methodology*. vol. 41. Hoboken, NJ: Wiley-Blackwell;
 74. Gordon, R. (1992) *Basic Interviewing Skills*. Chapter 9, Probing the Response for information, Ithaca: Peacock, pp-145-165.

75. Gourlay, J., Ricciardelli, L., Ridge, D. (2005). "Users' Experiences of Heroin and Methadone Treatment," *Substance Use and Misuse*, 40(12), pp. 1875-1882.
76. Greenfield, S. F. (2002). "Women and alcohol use disorders." *Harvard Review of Psychiatry*, 10 (2), pp.76-85.
77. Grella, C. E., & Joshi, V. (1999). "Gender differences in drug treatment careers among clients in the National Drug Abuse Treatment Outcome Study," *American Journal of Drug and Alcohol Abuse*, 25, pp. 385-406.
78. Grimm, J.W., Hope B.T., Wise, R.A., Shaham, Y. (2001). "Neuroadaptation: Incubation of Cocaine Craving after Withdrawal," *Nature*, 412(6843), pp. 141-142.
79. Harm Reduction International (2013). "Violence against Women who use Drugs and Access to Domestic Violence Shelters." Briefing Paper. Available at: [http://www.ihra.net/files/2013/03/19/Briefing_Paper - Access to Shelters - with correct fonts 07.03 .13 .pdf](http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03_13.pdf), Accessed: 17.12.13.
80. Herman, N. (1993). "Return to Sender: Reintegrative Stigma-Management Strategies for Ex-Psychiatric Patients," *Journal of Contemporary Ethnography*, 22(3), pp. 302-321.
81. Hodgins, D.C., Ed-Guebaly, N., Addington, J. (1997). "Treatment of Substance Abusers: Single or Mixed Gender Programs?" *Addiction*, 92(7), pp. 805-812.
82. House of Representatives, Standing Committee on Family and Human Services (2007) "The Winnable War on Drugs: The Impact of Illicit Drug Use on Families." Available at: http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=fhs/illicitdrugs/report.htm, Accessed: 26.09.13.
83. Humphreys, C., Thiara, R.K., Regan, L. (2005). "Domestic violence and substance use: overlapping issues in separate services?" Summary Report. London Domestic Violence Project: London. Available at: http://www2.warwick.ac.uk/fac/soc/shss/swell/research/final_report.pdf, Accessed 25.09.13.
84. Irwin, P.P. and Stoner, S.B. (1991). "Women's chemical dependency treatment program: A pilot study," *Alcoholism Treatment Quarterly*, 8, 123-130.
85. Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., Zabranski, T. (2012). Drug Situation in Georgia – 2012, Annual Report. Available at: <http://www.altgeorgia.ge/?lang=1&cat=27&id=55>, Accessed: 10.07.2013.

86. Javakhishvili, D.J., Sturua, L. (Eds.) et al. (2009). "Drug Situation in Georgia – 2009." Tbilisi: Southern Caucasus Anti-Drug Program.
87. Javakhishvili, J., Kariauli, D., Lezhava, G., Stvilia, K., Todadze, Kh. and Tsintsadze, M. (2006). "Drug Situation in Georgia – 2005." Tbilisi, Georgia: Southern Caucasus Anti-Drug Programme. Available at: <http://www.altgeorgia.ge/2012/myfiles/Drug-situation-in-Georgia-2005.pdf>, Accessed: 18.03.2013.
88. Japaridze, E. (2012). Assessment of the Gender Equality Policy in Georgia by Women's Organizations, Research Paper. Available at: http://css.ge/index.php?lang_id=ENG&sec_id=52&info_id=463, Accessed: 12.03.13.
89. Johnson, B. A. (2011). "Addiction Medicine: Science and Practice." New York: Springer.
90. Johnson, H. (1996). "Dangerous Domains: Violence Against Women in Canada." Toronto: Nelson Canada.
91. Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., Scott, R. (1984). "Social Stigma: The Psychology of Marked Relationships." New York: W.H. Freeman & Company; 1st Edition, pp. 5, 8, 24, 50, 56. 306.
92. Jorbenadze, L. (2012). "Legal Analysis of Georgian Drug Policy." Available at: <http://www.drugpolicy.dsl.ge/drugpercent20policypercent20research.pdf>, Accessed: 18.03.2013.
93. Kalton, G. and Anderson, D.W. (1986). 'Sampling Rare Populations,' *Journal of the Royal Statistical Society, Series A (General)*, 149(1) pp. 65-82.
94. Kanaiaupuni, S.M., Gans, M. (2005). "How Effective is Zero Tolerance?" Brief Review. Available at: http://www.ksbe.edu/spi/PDFS/Reports/Educational_Policy/04_05_23.pdf, Accessed: 26.04.2013.
95. Kaplan, H. B. (1975). "Sequelae of Self-derogation: Predicting from a General Theory of Deviant Behavior." *Youth and Society*, 7, pp. 171-197.
96. Kartvelishvili, S. (2013). "Why is it necessary to get rid of the 1990s?" Available: <http://lib.ge/book.php?author=1290&book=9239>, Accessed: 24.05.2013.
97. Katovich, M. and Couch, C. (1992). "The Nature of Social Pasts and Their Use as Foundations for Situated Action," *Symbolic Interaction*, 15(1), pp. 25-48.

98. Kaufman-Kantor, F. & Asdigian, L. (1997). "Gender differences in alcohol-related spousal aggression." In R. W. Wilsnack, & S. C. Wilsnack (Eds.), "Gender and alcohol: Individual and social perspectives" (pp. 312-333). New Brunswick, NJ: Rutgers Center of Alcohol Studies.
99. Kauffman, S.E., Silver, P. & Poulin, J. (1997). "Gender differences in attitudes toward alcohol, tobacco, and other drugs," *Social Work*, 42(3), pp. 231-241.
100. Kelly, J.F. and Westerhoff, C.M. (2010). "Does it Matter How We Refer to Individuals with Substance-Related Conditions?" A randomized study of two commonly used terms, *International Journal of Drug Policy*, 21 (3), pp. 202-7.
101. Kersey-Matusiak, G. (2013). "*Delivering Culturally Competent Nursing Care.*" New York, NY: Springer Publishing Co.
102. Kirtadze, I., Otiashvili, D., O'Grady, K.E, Zule, W., Krupitsky, E., Wendee M., Jones, H.E. (2013) "Twice Stigmatized: Provider's Perspectives on Drug-Using Women in the Republic of Georgia," *Journal of Psychoactive Drugs*, 45(1), p.1.
103. Klee, H., McLean, I., Yavorsky, C. (2002). "Employing Drug Users – Individual and Systematic Barriers to Rehabilitation," p. 4. Available at: <http://www.jrf.org.uk/sites/files/jrf/1842630830.pdf>, Accessed: 5.12.2013.
104. Koob, G.F., Le Moal, M. (2006). "Neurobiology of Addiction," *Elsevier Science & Tech.*
105. Laudet, A., Magura, S., Furst, R.T., Kumar, N., Whitney, S. (1999). "Male partners of substance-abusing women in treatment: An exploratory study," *American Journal of Drug and Alcohol Abuse*, 25(4), pp. 607–627.
106. Langan P., Levin D. (2002). "Recidivism of Prisoners Released in 1994." Washington, DC: Office of Justice Programs, Bureau of Justice Statistics; Dept of Justice publication NCJ 193427.
107. Lemert, E. M. (1951). "*Social Pathology: A Systematic Approach to the Theory of Sociopathic Behavior.*" New York: McGraw-Hill.
108. Link, B. G., Struening, E.L., Rahav, M., Phelan, J.C., Nuttbrock. L. (1997). "On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with a Dual Diagnosis of Mental Illness and Substance Abuse," *Journal of Health and Social Behavior*, 38 (1), pp. 177-190,
109. Lloyd, C. (2010). "Sinning and Sinned Against: The Stigmatization of Problem Drug Users." Available at: <http://www.smmgp.org.uk/download/rcgp-certificates/cert04/cert04-p03-d01.pdf>, Accessed:14.08.2013.

110. Loenieke, C., Van, B., Evelien, P.M., Jaap, V.W., Henk, F.L.G. (2013). "Stigma among Health Professionals towards Patients with Substance Use Disorders and Its Consequences for Health Care Delivery: Systematic Review," *Drug and Alcohol Dependence*, 131 (1), pp. 23-35.
111. Lomidze, G. (2012). Research conducted within the framework of the project 'Femina.' Gori: Union 'Step to the Future' (Unpublished).
112. Iowa Coalition for Domestic Violence, (2012). "Service Delivery Standards for Member Programs." Available at: <http://www.icadv.org/pdf/icadv-service-delivery-standards-march-2012.pdf>, Accessed: 17.12.13.
113. Major, B. and O'Brien, L.T.(2005) "The Social Psychology of Stigma," *Psychology Annual Review*, 56, pp.393–421.
114. http://marketing.conferenceservices.net/resources/327/3554/pdf/AM2013_0378_paper.pdf, Accessed: 18.10.13.
115. Martin, S., Kilgallen, B., Dee, D., Dawson, S., & Campbell, J. (1998). "Women in a Prenatal Care/Substance Abuse.
116. Mayberry, M. L., Espelage, D. L., & Koenig, B. (2009). "Multilevel modeling of direct effects and interactions of peers, parents, school, and community influences on adolescent substance use," *Journal of Youth & Adolescence*, 38(8), pp.1038-1049.
117. McIntosh, L. "Addiction Messenger." Available at: <http://atforum.com/addiction-resources/documents/MATPart2.pdf>, Accessed: 5.12.2013.
118. McLaughlin, D. and Long, A. (1996). "An Extended Literature Review of Health Professionals' Perceptions of Illicit Drugs and Their Clients Who Use Them," *Journal of Psychiatric and Mental Health Nursing*, 3 (5), p. 283.
119. McLellan, A.T., Alterman, A.I., Metzger, D.S., Grissom, G.R., Woody, G.E., Luborsky, L., et al. (1994). "Similarity of outcome predictors across opiate, cocaine, and alcohol treatments: Role of treatment services," *Journal of Consulting and Clinical Psychology*, 62, pp. 1141–1158.
120. McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., Durell, J. (1998). "Supplemental Social Services Improve Outcomes in Public Addiction Treatment," *Addiction*, 93 (10), pp. 1489–99.
121. Measham, F.(2002). "Doing Gender-Doing Drugs: Conceptualizing the Gendering of Drugs Cultures,"*Contemporary Drug Problems*, 29 (2), p. 335.

122. Melanie, C., Scott, P., Otto, F.W. (2011). "Substance Abuse Stigma and Discrimination among African American Male Substance Users," *Stigma Research and Action*, 1(1), pp. 60-66.
123. Merrill, J.O., Rhodes, L.A., Deyo, R.A., Marlatt, G.A., Bradley, K.A. (2002). "Mutual Mistrust in the Medical Care of Drug Users," *Journal of General Internal Medicine*, 17(5), pp. 327-333.
124. Merkinaitė, S. (2012). "A War against People who Use Drugs: The Costs." Available at: http://www.harm-reduction.org/sites/default/files/pdf/costs_report_2012_06_19_1_0.pdf, Accessed: 10.06.2014.
125. Miller, P.G. and Miller, W.R. (2009). "What Should We Be Aiming for in the Treatment of Addiction?" *Addiction*, 104 (5), pp. 685-6.
126. Moran, P.P., Vuchinich, S., Hall, N. (2004) "Associations between Types of Maltreatment and Substance Use During Adolescence," *Child Abuse and Neglect*, 28, pp. 565-574.
127. Murphy, S. and Irwin, J. (1992). "Living with the Dirty Secret: Problems of Disclosure for Methadone Maintenance Clients," *Journal of Psychoactive Drugs*, 24(3), pp. 258,262.
128. Najavits, L. M. (2002). "Seeking safety: therapy for trauma and substance abuse," *Corrections Today*, 64(6), pp. 136-139.
129. Nancy Poole and Colleen Anne Dell "Girls, Women and Substance Abuse." Available at: <http://www.ccsa.ca/2005percent20CCSApercent20Documents/ccsa-011142-2005.pdf>
130. National Institute on Drug Abuse (2011). "The Science of Drug Abuse and Addiction". Available at: <http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction> Accessed: 2.02.2013; 9 09.2012
131. National Institute on Drug Abuse (2012), "Principles of Drug Addiction Treatment: A Research-Based Guide" (Third Edition). Available at: <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>, Accessed: 10.02.14.
132. Nelson-Zlupko, L., Kauffman, E., and Dore, M. M. (1995). "Gender Difference in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women," *Social Work*, 40(1), pp. 45-54.
133. NIDA Community Drug Alert Bulletin - Stress & Substance Abuse. Available at: <http://archives.drugabuse.gov/StressAlert/stressalert.html>, Accessed: 16.04. 2013.

134. Nordin, V.D. and Glonti, G. (2006). "Thieves of Law and the Rule of Law in Georgia," *Caucasian Review of International Affairs* 1 (1). Available at: http://cria-online.org/1_5.html, Accessed: 18.03.2013.
135. Oetting, E.R. and Donnermeyer, J.F. (1998). "Primary Socialization Theory: The Etiology of Drug Use and Deviance." *Substance Use and Misuse*, 33(4), pp. 995-1026.
136. Oliver, K., Pearsall, M. (1998). "Introduction: Why Feminists Read Nietzsche," in *Feminist Interpretations of Friedrich Nietzsche*, Penn State Press, pp. 1-4.
137. Otiashvili, D., Sárosi, P., Somogy G.L. (2008). "Drug Control in Georgia: Drug Testing and the Reduction of Drug Use?" Available at: http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_15.pdf, Accessed: 18.04.2013.
138. Otiashvili, D., Kirtadze, I., O'Grady, K.E., Zule, W., Krupitsky, E., Wechsberg, W.M., Jones, H.E. (2012) "Access to Treatment for Substance-using Women in the Republic of Georgia: Socio-cultural and Structural Barriers." *International Journal of Drug Policy*, <http://dx.doi.org/10.1016/j.drugpo.2013.05.004>
139. Parkes, T., Welch, Besla, K., Leavitt, S., Ziegler, M., MacDougall, A., Armstrong, S., La Combe, B., LeClaire, M., Taylor, N., Cory, J. (2007). "Freedom from Violence, Tools for Working with Trauma, Mental Health and Substance Use." *Ending Violence Association of BC*. Available at: <http://www.endingviolence.org/files/uploads/FreedomViolenceIntro.pdf>, Accessed: 18.09.13.
140. Pinkham, S., Malinowska-Sempruch, K. (2007) *Women, Harm Reduction and HIV*, New York: International Harm Reduction Development Program of the Open Society Institute. Available at: <http://www.hivpolicy.org/Library/HPP001574.pdf>, Accessed: 26.09.13.
141. Platt, J.J. (1995). "Vocational rehabilitation of drug abusers," *Psychological Bulletin*, 117(3), pp. 416–433.
142. Pleck, E. (2004) "Domestic Tyranny: The Making of American Social Policy Against Family Violence from Colonial Times to the Present." Champaign, IL: University of Illinois Press
143. Powis, B. (1996). "The Differences between Male and Female Drug Users: Community Samples of Heroin and Cocaine Users Compared," *Substance Use and Misuse*, 31(5), pp.529-543.

144. Ptacek, J. (1988). "Why do Men batter their Wives?" In *Feminist Perspectives on Wife Abuse*, edited by Kersti Yllo, K. and Bogard, M. Newbury Park, CA: Sage.
145. Purposive Sampling as a Tool for Informant Selection. Available at: <http://scholarspace.manoa.hawaii.edu/bitstream/handle/10125/227/11547-3465-05-147.pdf>, Accessed: 29.09.13.
146. Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., Luty, J. (2009). "A study of stigmatized attitudes towards people with mental health problems among health professionals." *Journal of Psychiatry, Mental Health and Nursing*, 16, pp. 279–84.
147. Ravndal, E. (2003) "Childhood Maltreatment among Norwegian Drug Abusers in Treatment," *International Journal of Social Welfare*, 10, pp. 142-147.
148. Reed, B. G. (1987). "Developing women-sensitive drug dependence treatment services: Why so difficult?" *Journal of Psychoactive Drugs*, 19, (2), pp. 151-164.
149. Rico, N. (1997) "Gender-based Violence: A Human rights Issue." Available at: <http://www.eclac.org/publicaciones/xml/3/4743/lcl957i.pdf>, Accessed: 20.01.14.
150. Ridlon, F. V. (1988). "A Fallen Angel: The Status Insularity of the Female Alcoholic." Lewisberg: Bucknell University Press, p.25.
151. Roberts, J. V. (2003). "Penal Populism and Public Opinion: Lessons from Five Countries." Oxford: Oxford University Press.
152. Roberts, M., Bewley-Taylor, D., Trace, M. (2005). "Facing the Future: The Challenge for National and International Drug Policy." The Beckley Foundation Drug Policy Program Report 6. Available at: http://www.beckleyfoundation.org/pdf/Report_06.pdf , Accessed: 25.04.2013.
153. Roberts, A., Mathers, B., Degenhardt, L. "Women who inject drugs: A review of their risks, experiences and needs." Available at: http://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf, Accessed: 17.01.14.
154. Ronzani, M.T., Higgins-Biddle, J., Furtado, F.E. (2013). "Stigmatization of Alcohol and Other Drug Users by Primary Care Providers in Southeast Brazil," *Social Science & Medicine*, 69(7), pp. 1080-1084.
155. Room, R. (2005). "Stigma, Social Inequality and Alcohol and Drug Use," *Drug and Alcohol Review*, 25, pp. 143 – 155.
156. Room R. (2005). "Stigma, Social Inequality and Alcohol and Drug Use," *Drug and Alcohol Review*, 24, pp. 143–155.

157. Rosenbaum. M. (1980). "Women on Heroin." New Brunswick. NJ: Rutgers University Press.
158. Ruether, R.R. (1989). "The Western Religious Tradition and Violence against Women in the Home." Christianity, Patriarchy, and Abuse. Ed. Joanne Carlson Brown and Carole R. Bohn; Cleveland, OH: Pilgrim, p. 31.
159. SAMHSA (1997). "Substance Abuse Treatment and Domestic Violence." Washington, DC: SAMHSA.
160. Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M.G., Angermeyer, M.C. (2011). "The stigma of alcohol dependence compared with other mental disorders: a review of population studies," Alcohol Alcohol, 46, pp. 105–12.
161. Schur, E. M. (1971). "Labeling Deviant Behavior: Its Sociological Implications." New York: Harper&Row, Publishers, p. 24.
162. Schur, E. M. (1983). "Labeling Women Deviant: Gender, Stigma, and Social Control." Philadelphia: Temple University Press. p.81.
163. Scottish Social Attitudes Survey (2009). Available at: <http://www.scotland.gov.uk/Publications/2010/05/19111419/0>, Accessed: 9.10.2013.
164. Sen, G., Östlin, P. and George, A. (2007) "Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why does it exist and how we can change it?" Final Report to the WHO Commission on Social Determinants of Health. Available at: http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf, Accessed: 16.01.14.
165. Shaw, A., Egan, J., Gillespie, M. (2007). "Drugs and Poverty: A Literature Review." A Report Produced by the Scottish Drugs Forum (SDF) on behalf of the Scottish Association of Alcohol and Drug Action Team. Available at: <http://www.dldocs.stir.ac.uk/documents/drugpovertylitrev.pdf>, Accessed: 26.04.2013.
166. Shivy, V.A., Wu, J.J., Moon, A. E., Mann, S.C., Holland, J.G., Eacho, C. (2007). "Ex-offenders Re-entering the Workforce," Journal of Counseling Psychology, 54(4), pp. 466–473.
167. Sirbiladze, T. (2010). "Estimating the Prevalence of Injection Drug Use in Georgia: Consensus Report." Tbilisi: Bemoni Public Union.
168. Step to the Future (2012). Violence in the Families of Drug Using Women, Georgia, Gori, p. 11 (unpublished).

169. Stevenson, B. (2011). "Drug Policy, Criminal Justice and Mass Imprisonment," Global Commission on Drug policies, working paper prepared for the first meeting of the Geneva Commission. Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf, Accessed: 24.04.2013.
170. Stewart, S.H., Karp, J., Pihl, R.O., Peterson, R.A. (1997). "Anxiety, sensitivity and self-reported reasons for drug use," *Journal of Substance Abuse*, 9, pp. 223–240.
171. Taylor, S. (2008). "Outside the Outsiders: Media Representations of Drug Use," *Probation Journal*, 55940, pp. 369-387.
172. Todadze, Kh., Kavtiashvili, E., Khintibidze, Q. (2008). *The Assessment of Drug Treatment in Georgia*. Tbilisi.
173. Tolson, R. and Rychkova (2012). "No Woman Left Behind? The Limits of Reproductive Health and Rights for Women Who Use Drugs in Russia." Available at: http://www.centerwomenpolicy.org/programs/health/statepolicy/documents/REPRO_NoWomanLeftBehind_RebeccaTolsonandOlgaRychkova_000.pdf, Accessed: 19.06.14.
174. Toronto Drug Strategy Implementation Panel (2010). "Stigma, Discrimination and Substance Use: Experiences of People Who Use Alcohol and Other Drugs in Toronto." Available at: <http://www.toronto.ca/health/drugstrategy>, Accessed: 10.08.2013.
175. Treatment Program: Links between Domestic Violence and Mental Health," *Maternal and Child Health Journal*, 2(2), pp.85-94.
176. Tsogia, D., Copello, A., Orford, J. (2001). "Entering treatment for substance misuse: A review of the literature," *Journal of Mental Health*, 10, pp.481–499.
177. UK Drug Policy Commission (2010). "Getting Serious about Stigma: The Problem with Stigmatizing Drug Users." Available at: http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf, Accessed at: 9.10.2013.
178. United Nations Office on Drugs and Crime (2004), "Substance abuse treatment and care for women: Case studies and lessons learned." Available at: https://www.unodc.org/docs/treatment/Case_Studies_E.pdf, Accessed: 5.12.13.
179. United Nations Office for Drugs and Crime (2004). "World Drug Report." Available at: http://www.unodc.org/pdf/WDR_2004/volume_1.pdf, Accessed: 25.04.2013.

180. UNODC, (2004). "Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned." Available at: http://www.unodc.org/pdf/report_2004-08-30_1.pdf, Accessed: 17.12.13.
181. vanOlphen, J., & Freudenberg, N. (2004). "Harlem service providers' perceptions of the impact of municipal policies on their clients with substance use problems," *Journal of Urban Health*, 81, pp. 222-231.
182. Vigilant, L. G. (2008). "I Am Still Suffering: The Dilemma of Multiple Recoveries in the Lives of Methadone Patients," *Sociological Spectrum*, 28, pp. 278-298.
183. Vigilant, L. G. (2005). "I Don't Have Another Run Left with It: Ontological Security in Illness Narratives of Recovery on Methadone Maintenance," *Deviant Behavior*, 26(5), pp. 399-416.
184. Vigilant, L. G. (2001). "Liquid Handcuffs: The Phenomenology of Recovering on Methadone Maintenance," *Boston College Dissertations and Theses*.
185. Viner, R.M., and Taylor, B. (2007) "Adult outcomes of binge drinking in adolescence: Findings from a UK national birth cohort," *Journal of Epidemiology and Community Health*, 61, pp. 902-907.
186. Volkow, N.D., Wang, G.J., Telang, F., Fowler, J.S., Logan, J., Childress, A.R., Jayne, M., Ma, Y., Wong, Ch. (2006). "Cocaine Cues and Dopamine in Dorsal Striatum: Mechanism of Craving in Cocaine Addiction," *Journal of Neuroscience*, 26(24). pp. 6583–6588.
187. Wallen, J. (1992). "A comparison of Male and Female Clients in Substance Abuse Treatment," *Journal of Substance Abuse Treatment*, 9, pp. 243-248.
188. Walters, S. T. and Rotgers, F. (2012). "Treating Substance Abuse: Theory and Technique." New York: Guilford Press.
189. Weisman, M., Berman, M.E., Taylor, S.P. (1998) "Effects of Clozapate, Diazepam and Oxzepan on a Laboratory Measurement of Aggression in Men," *International Clinical Psychopharmacology*, 13, pp. 183-188.
190. White, W.L. (2009). "Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia" (with particular reference to medication-assisted treatment/recovery), Philadelphia: Department of Behavioral Health and Mental Retardation Services. Available at: <http://www.facesandvoicesofrecovery.org/pdf/White/StigmaMedicationTreatment.pdf>, Accessed: 6.08.2013.

191. WHO, UNODC & UNAIDS (2008). Principles of Drug Dependence Treatment. Discussion Papers. 1st ed. Vienna, UNODC.
192. Women's Health Victoria (2008). "Women and Drugs." Available at: http://whv.org.au/static/files/assets/030e652b/Women_and_drugs_GIA.pdf, Accessed: 5.12.13.
193. Wong, C. J., Badger, G. J., Sigmon, S. C., & Higgins, S. T. (2002). "Examining possible gender differences among cocaine-dependent outpatients," *Experimental and Clinical Psychopharmacology*, 10, pp. 316-323.
194. Xavier, J. (1999). "Passing as Stigma Management – An Analytic Review of Stigma: Notes on the Management of Spoiled Identity by Erving Goffman." Available at: http://learningtrans.files.wordpress.com/2010/11/jxavier_passing_as_stigma_management.pdf, Accessed: 18.08.2013.
195. Yllö, K.A. (1993). "Through a feminist lens: Gender, Power, and Violence." In Gelles, R.J. and Loseke, D.R. (eds.), "Current Controversies on Family Violence." Newbury Park, CA: Sage Publications, pp. 47-62.

Other Sources

Information obtained from: http://en.wikipedia.org/wiki/Social_stigma#Gerhard_Falk, Accessed: 4.10.2013.

Appendix 1

Interview Questions for Drug Rehabilitation Experts

Attitudes towards drug addiction and individuals with drug use problems

Please tell me about your working experience

Discussion topic 1: Could you please tell me something about drug situation in Georgia - Drug legislation, black market, drug prevention strategies, which drugs are most popular in the country and why

Discussion topic 2: Thinking generally about addiction, what is it? Why do people start to use drugs? Please list me the most common reasons of drug use; mostly at what age do people start to use drugs? What kind of problems and difficulties face people who have drug use problems in our society?

Discussion topic 3: What do you think about criminalized drug policy in Georgia, what negative and/or positive pitcomes has punishment and isolation of individuals with drug addiction from the society? Does harsh national policy help to prevent the addicted behaviour? what should be done and how?

Discussion topic 4: Societies attitudes towards people with drug use problems. How are the individuals with drug use problem perceived from the society?

Discussion topic 5: Is there any kind of gender difference in attitudes toward individuals with drug addiction? Please list me some peculiarities characterized for women who use drugs. What are the reasons for women to start to use drugs. Do men and women have different reasons while using drugs? Why? Can you please tell me what substance or substances are most popular in our society for men and for women? Why

Drug Treatment and Services

Discussion topic 1: Are there effective treatment options and services for drug addiction in Georgia? Please describe me this options and services. How long does rehabilitation take and how much does it cost?

Discussion topic 2: What is detoxification? What is substitution Therapy? What about inpatient or outpatient rehabilitation? Please tell me something about harm reduction services?

Discussion topic 3: What kind of problems and difficulties face people with drug addiction while entering a drug treatment facility? What are the gender differences between the patients during the treatment?

Discussion topic 4: Please list me the most widespread problems related to treatment facilities in Georgia? (The strength and weaknesses of treatment facilities) How should be these problems solved?

Appendix 2

Discussion Guide for Individuals with Drug use Problems

Some introductory Questions:

Please tell me something about yourself, who are you, how old are you; how do you live? Just describe me one ordinary day from your life. (Follow up questions – are you married? Do you have children, are you employed etc...)

General Questions about Addiction

Discussion topic 1: Let's talk about drug addiction, what can you tell me about drug addiction? What is it? Why does it happen, that people start to use drugs? Which drugs are most popular among Georgians? Why?

Discussion topic 2: Please tell me something about Georgian drug legislation; What are the strength and weaknesses of criminalized drug policy? Why? Please tell me how are individuals with drug use problems treated from the government?

Discussion topic 3: How would you describe those people who use drugs? How are individuals who are addicted to drugs perceived by the society? How are they treated? Why? What and how should societies attitude be changed? How do you think is there any gender difference in the attitudes towards people with drug addiction?

How would you describe a woman who is using drugs? Why?

Discussion topic 4: Let's talk about your own experience. When and how have you tasted drugs for the first time? Could you please describe the situation? What do you think, which factors triggered your choice and wish to taste drugs? When have you tasted the drug of your choice for the second time and how developed your addiction? Could you please describe the situation?

Discussion topic 5: Have you tried to keep your addiction in a secret from family or friends, or not? Why? Have you ever felt/feel a sense of shame about your addiction? Why? On which factors (Job, family relations, friends...) had your addiction negative effects? Have you ever lost someone or something because of your drug addiction? Please list me those problems which you encounter because you are addicted to drugs.

Attitudes towards Treatment Process and Services

Discussion topic 1: What do you know about drug rehabilitation options in Georgia? Have you heard about detoxification? Substitution? Other services? How would you describe me them? Why? Which treatment or other drug rehab services have you ever tried? Please tell me about your experience (Follow up questions: Please describe the method(s) of treatment which have you tried? Do you trust in the treatment? If not Why? How many times have you been in treatment?)

Discussion topic 2: What does the recovery process mean for you? Do you want to quit to use drugs? Why? What motivated/motivates you now or would motivate you to use treatment services and to recover from addiction? How do you think is it possible for people who are addicted to drugs to make a complete recovery? How? Please describe the process.

Discussion topic 3: Please tell me about the problems related to treatment, what are the weaknesses of treatment facilities? Do men and women with drug addiction face same problems related to treatment? What would you recommend to change in order to solve the problems related to treatment in Georgia?