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Learning To Live Without It:  
Women, Biography and Methadone

This paper addresses some issues relating to Methadone-maintenance as a treatment for heroin addiction. From the position of a sociologist in Melbourne, I am aware that New South Wales has had a vigorous debate about Methadone, mainly presented as a battle between the religious, dogmatic right and pragmatic health professionals and public health scientists.¹ There has been no such debate in Victoria. Methadone-maintenance has been presented as the best treatment for heroin addicts, with little or no comment being made as to its shortcomings and problems. This has been the case even though the Victorian Coroner had a major inquest into deaths related to Methadone in the 1990s.² I do not wish to be aligned with the religious right but, as a feminist and sociologist, I have misgivings about the widespread use of Methadone as a treatment and about the ideology of harm reduction as the only policy response to the issue of heroin addiction. Many of my misgivings become evident through the stories of women who have had experience of Methadone maintenance treatment. I have written of my general reservations about harm reduction policies in a previous article.³

Women’s relationship to all forms of drug use is quite different to men’s. With the exception of prescription tranquillisers, women use less of all drugs (and alcohol). This lesser use (and abuse) has been an excuse in the past to ignore the problems that drug abuse may have for women. However, since the 1980s, feminists have drawn attention to the gender implications in the way that drugs are used and abused. There has, nevertheless, been little critical discussion of the gender implications of recent drug policies such as harm reduction. The assumption seems to be that harm reduction is less punitive than abstinence based models, which therefore cannot be good for women. We need to unpack this assumption to develop policies which will be effective for certain groups of women.

This article is about a group of women who have been active heroin addicts in the past and who had experience of Methadone-maintenance treatment (MMT) before becoming totally drug-free. My intention is to try to understand public health policy through the individual lives of women who are experiencing the pointy end of...
modern drug addiction policy and thereby question the meanings we
give to the term ‘harm reduction.’ The goal of harm reduction is the
minimisation of the social, psychological, and personal damage of
drugs and, while this is a laudable goal, it can take on the flavour of
a platitude with little understanding by the layperson of what its
effects are on those who live with it. In the world of public policy
and treatment, harm reduction and abstinence are placed in
opposition to each other. The choice of abstinence is considered a
failure on the part of the woman since she clearly has not developed
the necessary qualities of a ‘rational liberal’ citizen. This paper tells
a story of the clash between a state policy (backed by an army of
health professionals, researchers and bureaucrats) and some women
who have experienced a central part of this policy.

For me the question is always: harm reduction for whom? If it is
for the addict, then we must ask the addicts for their shared
meanings of the term. If it is for the relatives and friends of the
addicts, then they should be asked. If we are talking about harm
reduction for other parts of the community, then it is up to the
policy makers to clarify who they mean when they use the term.
These are complex issues and cannot adequately be covered in one
short article, so I will limit myself to the group of women that I
interviewed and portions of those stories that I will tell. I present
their meanings as told to me.

Biography, autobiography and science
Biographies are strange things; they presume to tell the truth but
never the whole truth. Biographies are like many other narratives,
they have a beginning, middle and end but the structure is always
moving so that the beginnings for my purposes here are really the
middle of the interview, and the middle of the life as it has been
lived by the narrator. Because autobiographies and biographies are
so messy, the scientific project finds them hard to deal with. No
biography can allow us to see the graph representing the cut in the
crime rate, or the table with the percentage of HIV and hepatitis in
the population. The ideology of harm reduction policies is based on
public health science; this in turn is based on epidemiology, not on
the life and experiences of individual addicts. Nonetheless, individual
experience is ultimately important for public health and the policy
formulations that we help to make. Individual addicts are often
trotted out for the benefit of the media when a new rehabilitation
centre is opened or a new drug comes out to solve the problem. But these are not the stories to be presented here.

Needless to say, autobiography is important to the person who is narrating it. Through telling our own stories we validate our own experiences; through telling stories of experiences relating to addiction and treatment, women are able to make their own experiences speak as a universal singular. When we speak, we speak not just about our individualised experiences, but also of our part in the whole social world. But we do not speak for the world, but for ourselves.

Feminists have to start speaking about the nature of addiction. We also have to engage with the hegemonic ideology that is harm reduction which explains itself as part of the social enterprise, but dismisses the experiences of those who have not benefited from their policies. When we listen to women’s experiences, we allow this critique to begin.

**Harm reduction and the New Public Health**

Harm reduction or harm minimisation is the official policy of both the Australian and Victorian governments in relation to drug use and abuse. However, it means different things to different people. In relation to heroin, harm reduction has meant drug substitution programmes such as Methadone, as well as needle-exchange programmes and other measures such as counselling. Some Naltrexone-treatment clinics are also in operation. (Methadone and Naltrexone operate physiologically in very different ways—Naltrexone blocks the effects of heroin, while Methadone is a chemical substitute for opiates. In effect Methadone is a legal addiction, but an addiction nevertheless.)

Harm reduction is essentially derived from the New Public Health models which emphasise such concepts and strategies as health promotion, education, social marketing, community participation and intersectoral collaboration. In contrast to the biomedical model of health which is based on individualist notions of health and illness and centres its own enterprise on the individual body, public health is presented as a social enterprise. It is a psycho-socio-epidemiological model. The main tool of public health is epidemiology which relies on statistical analysis and probability theory. Public health is a utilitarian enterprise. It is the greatest good for the greatest number at the lowest possible cost.
Generally, this has been interpreted as meaning that the state spends the least amount of money for the best return in relation to health or prevention of disease. This form of policy may pit the individual against the so-called common good. This has repercussions for all women, and women addicts in particular. Does the state spend its limited resources on dealing with rehabilitation for individual addicts which may be costly and take time, or act in the best utilitarian fashion and spend its money to deal with the greatest number, even if the results are not positive for individual addicts?

The ‘new public health’ model has also been called ‘surveillance medicine’ and the ‘epidemiological clinic.’ Changing the focus from the individual body with an illness, here we have an emphasis on the social characteristics of whole groups using profiles of populations. Identification of risks and risk behaviour in populations has been a major part of preventive strategies in public health. Health promotion has meant the diffuse targeting of risk groups by large-scale advertising and media interest. Women as mothers and carers have become prime targets of this promotion. Cook notes:

There is a paradox in addressing women’s practical and strategic needs: those concerned with practical needs may develop concepts whose effects, and perhaps whose purpose confine women to maternal, domestic and subordinate social roles. This denies women’s legitimate strategic needs and prevents them from flourishing to their full capacity within the family, community and society.

Ironically, the ‘new public health’ also ignores the very real social nature of women’s health problems. In relation to tobacco smoking, for example, Graham illustrates the problems which exist when we understand that the highest levels of smoking are concentrated in the poorest groups of women, and that health promotion which relies on persuading individual women to cease smoking for the health benefits to their children completely ignores the benefits that better housing, secure incomes and adequate schools have on reducing smoking rates. In a world which is increasing inequality, the best public health policy is one which relies on individual citizens changing their individual habits.

Sociologists have argued that public health measures have entailed greater amounts of surveillance by health professionals over individuals, greater monitoring of risk behaviours by the individuals themselves, and the entrenching of women’s normative roles as
mothers and carers by devolving care to the community while presenting women as the most amenable group to public health messages. However, women are also among the most economically disadvantaged groups within our society and women addicts have the double burden of addiction and gender to deal with.

### Treatments for drug addiction

Different models of treatment for drug addiction are as much based on moral and legal responses to drug usage in general, as they are on scientific and medical theories. I would argue this is the same problem for abstinence-based models as for harm reduction or harm minimisation models. Essentially, there are four models of treatment with a high number of variations. These are:

1. Abstinence-based professional treatment models.
3. Harm reduction or harm minimisation models, which include Methadone and other drug substitution programmes, controlled drinking programmes, safe use education programmes, needle exchange programmes etc.

All these models are gender-blind. That is, there are no models specifically directed to women and women's needs. Women addicts have either been completely ignored, or it has been assumed that they have similar needs to men. The only exceptions are those policies directed to women as mothers. The United States has also been the focus of pro-natalist policies in relation to pregnant women and substance abuse which posits women's autonomy against their responsibilities towards the babies they are carrying.

Feminist critics have long argued that gender-blindness works to disadvantage women when it comes to addiction to drugs. Ettorre notes that the language used in relation to addiction and substance use points to the problem. Dependency, for example is a two-edged sword. She argues that particular forms of dependency are deemed 'good' for women while others are universally condemned. A woman's economic dependence on a man is considered part of normative femininity, and even dependence on prescription tranquilizers is generally ignored if a woman manages to carry on her family responsibilities more or less successfully. Dependence on heroin is not an acceptable dependency because there is too much of
a risk that women will be unable to carry out their prescribed duties as wives and mothers.

The four models of treatment read diverse and contradictory effects for women. Abstinence models clearly limit people’s autonomy in relation to notions of choice. Residential treatment facilities generally operate to limit people’s movements in and out of the programmes. Many women complain that they cannot take part in residential programmes if they are separated from their children or they do not have the family resources to place the children. In the American context, Iris Young is very suspicious of most treatments for drug addicted women, arguing that ‘treatment often operates to adjust women to dominant gender, race and class structures and depoliticizes and individualizes their situations.’

Abstinence may or may not be based on legal prohibition of drugs. As with alcohol, an abstinence model may well operate within a legal environment which supports the recreational use of a drug. Some proponents of harm reduction argue that this approach essentially makes no comment on legal or moral issues in relation to drug use, it is only concerned with public health issues. But as I have noted above, public health is as much concerned with political and ideological notions, as is any other human institution. Many harm reduction proponents argue that the issue of drug abuse should be taken out of the hands of the law and put into those of health professionals. This is supposed to enhance the human rights of addicts, but it takes no account of informal measures of social control and increased surveillance by many professionals which may decrease the human rights of addicts. While a woman in jail clearly finds the level of social control overwhelming, surveillance by doctors, psychologists, social workers and even pharmacists outside of the prison system may be just as effective in enforcing normative and prescriptive gender roles.

Abstinence-based 12 Step mutual self-help groups such as Alcoholics Anonymous or Narcotics Anonymous are also victims of contradictory forces. On the one hand they are free of professional control and surveillance and operate on democratic principles. They are also examples of the way that social capital can be built up in previously disempowered groups. However, there is continuing debate among writers about aspects of their operations, and some feminists argue that they are based on models of normative gender prescriptions which are disempowering in themselves.
Since the mid 1980s in Australia, drug substitution programmes such as MMT as well as other harm reduction measures such as syringe exchanges and education have been implemented. Naltrexone treatment has also begun to be available. The introduction of various programmes including MMT and needle-exchanges have been presented by policy makers as resulting from systematic, scientific studies in what is now referred to as evidence-based health policy. However, a reading of the literature indicates that, while there have been many scientific studies involving statistical survey analyses, there are many problems with comparisons between them because of differences in data collection techniques, study participants, types of programmes and many other variables. The introduction of syringe-exchange programmes came not as a result of scientific studies, but from intelligent hunches about the groups likely to spread HIV into the non-addict and heterosexual population.

Differences in treatment goals also inhibit substantial comparisons. These problems led Heather and Tebutt in 1989 to argue that up to that point there had been no clearly effective treatment for heroin addiction. No clear treatment has as yet emerged, although Methadone maintenance is still considered the most effective medical one. However, successful medical treatment may not necessarily equate with successful social or individual outcomes and there have in the past been many medical treatments that have later been judged negatively—much of what passed for gynecological surgery in the nineteenth century and frontal-lobe lobotomies in the twentieth, are two instances that come to mind.

While some studies of drug treatments have used gender as a variable, few view gender as worthy of exploration in its own right. When studies do look at the importance of gender for those who go into treatment, it has been found that women and men are really two quite different groups of clients. Women and men have been found to have used drugs differently, women have been found to have more emotional and physical symptoms than men do on entering treatment, and women are in general poorer and have more children for whom they are responsible. Women also tend to be younger than men on entry to drug treatment. With these major differences between the situations of women and men, I think we need to be careful when suggesting that MMT, or any other treatment, operates in the same way for women as for men.
The study
This research is a very small qualitative study of six women who are now totally drug free and who have used Methadone or cared for users of it. The Methadone was legally prescribed, not bought on the streets. All the women had very negative experiences, and thus do not represent the experiences of those for whom Methadone has worked to free them from heroin use.

This being said, these women’s experiences are valuable in understanding how a variety of methods are needed to help women with addiction problems. Their experiences also help to demystify the whole issue of abstinence from drugs since all of the women finally came to abstinence by their own choice and now lead (in their own terms) productive lives. 25

The women in this study were aged between 35 and 50. All had been drug free for over 18 months, the longest time being 12 years. Four of the women cared for children during their lives in addiction. All the women had committed crimes to sustain their addictions—one had been a sex-worker, one had stolen from her place of work and the others had been involved in the sale and distribution of drugs. Three of the women had been arrested, but only one had been to jail. The women had also used other drugs including alcohol, marijuana, amphetamines, and prescription drugs such as barbiturates. All continued to use heroin while on Methadone. All of the women at some point became members of Narcotics Anonymous.

The next section of the paper will present some of the women’s experiences in their own words.

Life with Methadone
As I have already noted, people’s stories are rarely presented in clear, thematic narratives. While the women’s stories were, for the most part, presented as standard biographical narratives with beginnings, middles and ends, I have broken them up to suit my purposes in this paper. I will begin at the beginning of the Methadone story—not the beginning of the addiction story, that is for another time.

None of the women went on Methadone because they wanted to; each felt compelled to begin because of the threat of jail or fear of being caught using heroin. All of them had used heroin and other drugs for many years.

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I went on the Methadone as a stretch to keep out of jail. I was going up before the magistrates again…. I had just gotten off a suspended sentence and the lawyer suggested that I really had to go to the magistrates and give them a good reason to keep me out of jail. And so Methadone was part of that. (Betty)

I was put on Methadone by the psychiatrist … the day after I first got arrested…. For fraud. (Robyn)

I used to quite enjoy getting stoned but there was the guilt and I knew I was doing things against my own will…. I went on Methadone … it was something I didn’t want to do and I knew it didn’t work. I’d seen people use Methadone and use [heroin] every day that they were on Methadone but I was desperate. (Sue)

For Penny, the initial dose was too high and she asked for it to be lowered.

First, I actually had to get my Methadone taken down because I just kept falling asleep all the time and I couldn’t do anything. I would have to wake up in the morning and write myself notes, before I picked my dose up, so I could actually remember what to do.

Betty asked to cut down the initial dose so that she could still get high on heroin:

When I went on Methadone I got up to 70mls and [it was] a bit pointless using it because you had to use a lot of dope, so I actually got them to cut down my Methadone to 40, so I could use [heroin].

All the women were given individualized treatment. By that I mean they were not directed to any group-based treatment. All but one were given prescriptions which they then went to the chemist to fill. This was really drug addiction treatment on the cheap.

There are, however, problems with Methadone clinics as well. Rosenbaum and Murphy found that success on Methadone programmes for women often meant an inability to separate themselves from the programme at all.26 Ironically enough, being considered a success among clinic staff and clients proves to be an obstacle to getting off Methadone. Those who have status around the clinic enjoy a certain amount of respect and admiration.

There are people who successfully detox from Methadone and remain opiate and Methadone free. They do exist. But they are not visible to men and women currently on Methadone. One of
the reasons they have been able to ‘make it’ and remain opiate-free is they have separated themselves from the clinic environment.²⁷

None of the women here spent any time at a clinic and all had negative experiences of Methadone. Many women choose MMT and gain positively from the treatment. This group of women clearly did not.

Penny describes the stigmatisation of individualised treatment. There is no group reinforcement or validation of experience when you pick up your dose at the chemist.

The very first day I picked my Methadone up the chemist said to me: ‘Now this is the protocol, you don’t come to the shop when there’s lots of people here, you stay in this corner.’ It was like, ‘this guy is not here to help me.’ ‘We want your thirty five bucks a week.’ He made that really clear. I always felt sick and I don’t know if that was the combination of the hepatitis but I always felt like my bones were aching, I felt cold all the time, sweated a lot, my sleep patterns were hideous. (Penny)

Penny also describes the physical symptoms experienced by many people on Methadone but routinely dismissed by health professionals as non-existent. Sue also had many distressing physical problems.

I think my teeth got a little bit worse…. I couldn’t sleep, I sweated because of the Methadone—that makes you pour sweat, horrible stuff. (Sue)

MMT did provide some of the women with relief from some of the most severe aspects of their addictions.

Methadone held me, I didn’t hang out.²⁸ (Sue)

It cut down my use [of heroin] because I wasn’t in such a desperate manic state to go and get the dope. So it did, it made me a lot calmer in the morning, because I knew I could get my dope and I’d be okay. I wasn’t in so much emotional turmoil. (Betty)

I was able to maintain a reasonable habit and no, it wasn’t costing me too much. (Penny)

Part of harm minimisation is to lower the cost of addiction to the individual addict, and at this level MMT was helpful. However it did not stop the criminal activity that Betty was involved with (she was trafficking heroin), nor did it stop the women using heroin. MMT did ameliorate the worst aspects of heroin addiction such as some withdrawals. The problem came when the women wanted to
withdraw from the Methadone. This part of the story comes later.

MMT in Victoria has been administered a number of ways, through specialist clinics and on prescription from individual general practitioners. Penny has already described the scene at the chemist shop. In Victoria it has only ever been administered as syrup for oral consumption.

Yeah, you just took it in a little cup, there was a little juice mixed in it, little bit of orange juice and just drink it. (Betty)

This was [a large private] Hospital; so he [the physician] had a clinic there and we’d just go in and get whatever we could get. We might get up to two days’ dose as take-aways. ... I don’t know if it was exceptional that they gave us that many. Bottles at that stage got bigger. They initially used to get tiny little packs of bottles so then they started giving us big bottles of this cordial. (Sue)

As I have already mentioned, all the women used heroin while on Methadone.

I think the most I went without [heroin] was three days. It [her habit] was still governed by the amount of money more than the fact that I wasn’t hanging out any more.... For the last twelve months I was using [heroin] because it [MMT] just wasn’t doing for me what I thought it would do. (Sue)

Interviewer: Did you use less heroin when you were on the Methadone?
Penny: I did yeah, I was able to maintain a reasonable habit and no, it wasn’t costing me too much.

Interviewer: I guess that’s one of the arguments about Methadone maintenance; you can’t stop your heroin use altogether, at least you cut it down.
Penny: Yeah and it cuts the cost down to the community too, I guess.

Interviewer: Did you stop thieving and other illegal activities while you were on the Methadone?
Penny: Not really.

Life without Methadone

All the women described extremely negative experiences of withdrawal from Methadone, both for themselves and the people they cared for.

I had one friend that I helped withdraw from below 40mls, and
he'd been on a 180ml block-out programme for ten years.... He
was a shell of his former self though, he'd lost all his teeth, hair,
his bones were disintegrating and he had to be watched twenty
da day, because if he fell asleep he would quite often
vomit and start to suffocate. I had never seen anybody so sick.
(Jenny)
I remember the first time I went off Methadone. No one told me
I was going to be very sick, so I thought I'd gone mad. I locked
myself in the room for three months, with Rohypnol [a
prescription drug], and would only come out at night when
everyone went to bed, and then go back as soon as everyone got
up. I lived in there for three months. No one ever told me what
happens. (Robyn)
Roger [her husband] had actually been on it [Methadone] the
year before for three months. His mother lived up in the country
and we went up there [to help him withdraw from Methadone].
He got so sick, it was really scary. His body was convulsing and
he was popping heaps of sleeping tablets. I ended up sticking
him in the back of the car. It was an eight-hour drive and we
drove back to Melbourne and God, it was pretty scary.... I got
down to twelve mls, then I jumped off.... On the fifth day I was
really sick. The worst thing with my withdrawal from heroin
was lack of sleep.... But I was just so sick of this Methadone,
I'd fall back to sleep, wake up, throw up green bile in the end.
Interviewer: So it was really severe?
Sue: Yeah. I couldn’t believe it.
Even in the light of the positive aspects of MMT and the fear of
withdrawals, the women decided to finish with Methadone, anyway.
Betty stopped her MMT for rather mundane reasons, she lost the
use of the car that took her to the clinic in another town and she did
not go through withdrawals because she was using enough heroin to
see through. Penny went back to using heroin as a means of
withdrawing from Methadone and then she detoxed from the heroin
itself.
It was too much of a tie, an addiction; it's using.... We could
never do anything except two days at a time. Two take-aways
was the most we could ever get, so you could have a three day
sojourn away from Melbourne. (Sue)
That would be the same as being using all the time ... it’s like I
have no control in my life whatsoever. If I could use and keep

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my life, manageable, I would. I’ve no doubt about that one, but because it [Methadone] overtakes every single aspect of every waking moment, just to have that removed is so magnificent. (Robyn)

So finally all the women got to the end of their active addiction stories. They could no longer carry on in the way they had, in one instance for over 25 years. They had children to look after and/or they wanted to regain some control over their lives. Eventually they each came into contact with someone in Narcotics Anonymous. As a member of Narcotics Anonymous each woman could eloquently describe the effects of a drug-free life.

The one thing that total abstinence does for me is that it meets the needs in me. I felt socially inept but when I did take drugs, I felt good. And the thing that was really important to me as a teenager is the same things now, to be part of a group, having friends, being comfortable with who I am, having fun, everything that makes a person happy, and harm minimisation doesn’t give me that. I’ve been through various treatments; the reason why NA works for me is because it gives me a group, gives me a community where I belong. In our day and age we used to have churches for that, we used to have clubs and societies. Church doesn’t mean that much any more, I think NA has become my church. I got into drugs because we had our own little language, we were in a little tribe, in a little group, together, we didn’t feel alone, I had my part in the world and that’s what NA has done for me. So harm minimisation doesn’t answer any of those primary needs that I took drugs for in the first place. Methadone as harm minimisation didn’t work for me, because when I took Methadone it was the same thing. I was still socially inept; I was still uncomfortable in my own skin. (Betty)

It [Methadone] overtakes every single aspect of every waking moment, just to have that removed is so magnificent. Maybe NA is a little bit like that but I can fit that into my life where I want. If I was on some form of medication, I wouldn’t have so much control over it. (Robyn)

I think they [addicts] need a support network. I used to have an argument with the Methadone doctor over this because finally when the urine kept coming back dirty [positive for heroin], he said: ‘I’ll put you up.’ I never went over 45 [mls] because I really didn’t want to, and he kept saying: ‘I’ll put you up, you’ll
stop using.' I said: 'I won't stop using, I don't hang out now ... I want to stick a fit in my arm. I want to use smack even if I only get a bit of a feeling (which is what it was in the end). It's here [pointing to her head] and all the Methadone in the world isn't going to take it away.' And he wouldn't recognise that.

(Sue)

There is a large literature about Narcotics Anonymous and other 12 Step groups some of which is critical and some not. The important point I would like to make here is that much MMT is carried out in doctor's surgeries and does not involve women with others in groups or communities. 12 step groups (with all their problems) give many disempowered individuals the possibility of meaningful community contact.

Robyn also points out that what she (and the others) wanted was control over her life, this was something a drug free existence could provide for her, but with Methadone she was always in the position of being controlled by a drug and those who dispensed it. It is often assumed that autonomy and community are oppositional. I would argue that autonomy cannot exist without community.

What do the stories tell us?

These women are the small percentage of women who have become totally drug free. They no longer use heroin and they do not drink or smoke marijuana. Methadone was, for them, as controlling as was heroin and they finally found a spot where they could decide to become drug free. Indefinite MMT does not allow for a drug free existence. It also means constant surveillance from pharmacists, doctors, nurses and welfare agencies. The surveillance clinic that Castel discusses is the Methadone clinic.

MMT is also an individualising phenomenon when it is prescribed by a GP. There is no supportive community, no place where addicts belong. Narcotics Anonymous provides this community, but it is criticised by health professionals for its disease model of addiction and anti-professional stance. Elsewhere, however, I have argued that much of what passes as scientific criticism is really professional protection of terrain. There are other non-professional groups which could probably do the same job for addicts, but these are not prominent in Australia.

The role of women as carers does not disappear for women addicts and the severity of Methadone withdrawal is highlighted for women.
with Methadone-addicted partners. Current Victorian government policies of deinstitutionalisation and community caring transfer the responsibilities of care to individual women. Withdrawal from heroin is severe enough; helping someone withdraw from Methadone can be overpowering. When official policy privileges harm reduction measures over abstinence, there is little support given to those people who desire to detoxify from Methadone. These women’s experiences demonstrate the difficulties of this issue for individuals, positive outcomes of MMT for the community notwithstanding.\(^{32}\)

MMT needs much more attention from feminists who are interested in the subject of women and drug addiction. It cannot be assumed that the various components of harm reduction are automatically gender friendly. Feminists should not be cowed (as have been many sociologists) into not criticising components of harm reduction because they might be seen as aligning themselves with the non-feminist right. As Room noted in relation to sociologists, the fear of being seen as wowsers or being accused of temperance sympathies led to more than fifty years of silence in relation to alcohol policy and its implications.\(^{33}\) The negative experiences of MMT detailed by the women here are clearly not universal, but they are serious enough to question the widespread belief that drug-substitution programmes are the only options for drug rehabilitation policies. Bureaucrats who are carrying out economic rationalist agendas are increasingly operating drug policies. Just as many of us are openly critical of economic rationalist policies in education, health and many other areas, so we should be as critical of these policies when they impact upon individuals with drug problems, particularly in the ways they impact upon women.

Grazyna Zajdow

Notes:

1. In Queensland this year there was some (largely media) discussion of Methadone, and criticism of it as the state-favoured treatment following the attempted closure of a Naltrexone treatment facility in West End in Brisbane. This was alleged due to irregularities in drug-prescription procedures on the part of the doctor (a very public Christian). Following a demonstration at Parliament by addicts, their parents and friends, the closure was averted. [Eds.]
4. D. Hawks and S. Lenton, 'Harm Reduction in Australia: Has It Worked? A Review,' *Drug and Alcohol Review* 14 (1995): 291-304. Harm reduction in relation to legal drugs may mean limitations on the availability of the drugs to particular groups such as young people and printing potential dangers on the products themselves such as the label on cigarette packets. But here we strike the difference between use reduction and harm reduction. We want to stop young people smoking altogether rather than teach them how to smoke safely. Although the cessation of all drug use is lauded by many of the proponents of harm reduction, a reading of the literature suggests that the harm reduction and use reduction are mutually exclusive (see A. E. Roche and K. R. Evans, 'Harm Reduction: Roads Less Travelled to the Holy Grail,' *Addiction* 92.9 (1997): 1027-1213.

5. Naltrexone treatment is still very controversial and not readily available in many states. Currently in Victoria, Naltrexone is being hailed by a number of general practitioners and state-run clinics. There is no consensus, as yet, on its value in treating heroin addiction.


12. Nettleton, 'Women and the New Paradigm'; Graham, 'Women's Smoking.'


20. Of course, feminists have also criticised scientific methodologies as reflecting masculine notions of appropriate forms of evidence.


25. The small percentage of addicts who become abstinent (about 15% at any one time) is often used as the major reason for not presenting abstinence as a viable option for them. However treatments for many other life-threatening conditions have often only saved a small percentage of people (I am thinking of many past cancer treatments or even organ transplants) and this has not stopped the health system from funding them.


27. Rosenbaum and Murphy, 'Always a Junkie,' p. 531. Italics in original.

28. 'Hanging out' means going through withdrawals while waiting for the next dose of heroin.


30. Zajdow, 'Civil society.'

31. Zajdow, 'Civil society.'
